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TENNESSEE RECORD MANUAL

FOR COUNTY HEALTH DEPARTMENTS

REVISED EDITION - 1948

TENNESSEE DEPARTMENT OF PUBLIC HEALTH

R. H. Hutcheson, M.D.
Commissioner of Public Health

NASHVILLE, TENNESSEE

1948

TENNESSEE RECORD MANUAL

FOR COUNTY HEALTH DEPARTMENTS

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TENNESSEE DEPARTMENT OF PUBLIC HEALTH

W. H. HARRISON, M.D.
Commissioner of Public Health

KNOXVILLE, TENNESSEE

1948

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FOREWORD

Plans for the development of records in Tennessee were begun in 1928 with a Records Committee composed of Dr. Harry S. Mustard, Dr. Joseph W. Mountain and Miss Carolina Randolph appointed by Dr. E. L. Bishop, the Commissioner of Health. They were concerned with developing basic records for recording the medical, nursing and sanitation services. Experimental records were placed in use in July, 1929 in five local health departments. As a result of this field trial a uniform record system was proposed for Tennessee. The first *Record Manual* was ready for use on April 1, 1930.

Since that date Records Committees have met at frequent intervals for further revision of individual records and for designing and approving new records submitted by health workers.

During the past year and a half the Records Committee has met at bimonthly intervals for a full day session for review and revision of the records and the instructions in use. Due to changes in procedures, often the instructions were out of date and thus revisions were advisable at this time. By use of multilithing equipment a new method of presentation of material in the *Tennessee Record Manual* was developed. In the past, the record has been attached to a sheet of paper and the mimeographed instructions were placed on the following page. By use of the multilith process pictures of the fronts and backs of the records have been taken and reproduced on one page. The large records have been reduced with the actual size given in the space below the name of the record. The instructions follow the pictures of the records.

Numbers have been assigned to the records by type of service using the following system:

Administration	1-99
Vital Statistics	100-199
Preventable Diseases	200-299
Sanitation	300-399
Maternal and Child Hygiene	400-499
Miscellaneous	500-599
Laboratory	600-699
Tuberculosis	900-999

In the appendix are given *General Instructions for Reporting and Filing* and *Reference Material Furnished by the Department of Public Health*. A detailed index follows the appendix.

These records and instructions have developed through the participation of all health workers in Tennessee. The contributions of the workers in county health departments have resulted in this *Tennessee Record Manual*. This Manual will be revised continually to meet the needs of the growing and ever-changing public health program. Continued cooperation in developing and improving our records and procedures will be appreciated.

R. H. Hutcheson
Commissioner of Public Health

FRONT

BACK

TABLE OF CONTENTS

SECTION	FORM NUMBER
Administration	1-99
Vital Statistics	100-199
Preventable Diseases	200-299
Sanitary Engineering	300-399
Maternal and Child Hygiene	400-499
Miscellaneous	500-599
Laboratory	600-699
Tuberculosis	900-999
Appendix	App. 1-99
General Instructions for Reporting and Filing	App. 1-5
Reference Material Furnished by Tennessee Department of Public Health	App. 10-16
Index	

DAILY REPORT SHEET - FORM 1
SIZE 4 $\frac{1}{4}$ " x 7 $\frac{1}{4}$ "

FRONT

BACK

[illegible][illegible]

PURPOSE: For recording day's activity, and as basis for monthly tabulation.

EXPLANATION AND DEFINITION:

Code Number: This space is used for code numbers for the service rendered. Do not record any other item in this space.

USED BY: All Field and professional workers.

OFFICE MECHANICS AND FILING: Daily report sheets fit into loose leaf notebook, and are carried into the field. At the end of each day, report sheet is removed from notebook and handed in to clerk. Attached to it are all records for that day. Clerk keeps each worker's sheet filed as unit for the month, using U-File-M Binders. At the end of the month, the clerk summarizes all dailies, compiles them for the monthly tabulation, and submits it to the health officer. After the monthly tabulation is made, dailies are filed for future reference. They are readily available if filed for individual workers for the fiscal year.

NOTE: Notebooks may be obtained through State Department of Health. U-File-M Binders, 11 inch strip, U-File-M Binder Manufacturing Company, Syracuse, New York.

CODE FOR DAILY REPORT - FORM 2
SIZE 7 $\frac{1}{4}$ " x 4 $\frac{1}{4}$ "

SHEET 1

CODE FOR MONTHLY TABULATION

A. COMMUNICABLE DISEASE CONTROL

1. Admissions to service
2. Consultations with physicians
- Field Visits (cases, suspects, carriers):
3. Diphtheria
4. Typhoid fever and paratyphoid fever
5. Scarlet fever
6. Smallpox
7. Measles
8. Whooping cough
9. Venereal diseases
10. Other (specify)
- Immunizations (persons immunized):
11. Smallpox (including revaccinations)
12. Diphtheria - under 1 year
13. Diphtheria - 1 year
14. Diphtheria - 2 years
15. Diphtheria - 3 years
16. Diphtheria - 4 years
17. Diphtheria - 5 years and over
18. Typhoid fever
19. Whooping cough - under 1 year
20. Whooping cough - 1 year
21. Whooping cough - 2 years and over
22. Other (specify)

B. DENTAL HYGIENE

1. Preschool inspections
2. Preschool individuals admitted
3. Preschool operations
4. Preschool individuals completed
5. School inspections
6. School individuals admitted

SHEET 2

B. DENTAL HYGIENE (Continued)

7. School operations
8. School individuals completed
9. Other (specify)

C. TUBERCULOSIS CONTROL

1. Individuals admitted to medical service
2. Cases admitted for first time to nursing service
3. Cases previously admitted given nursing service
4. Contacts and suspected cases admitted to nursing service
5. X-ray examinations of cases
6. X-ray examinations of contacts
7. X-ray examinations of others
8. Clinic visits
9. Visits to private physicians
10. Field nursing visits to cases
11. Field nursing visits to others
12. Office nursing visits to cases
13. Office nursing visits to others
14. Admissions to sanatoria
15. Patients admitted for pneumothorax treatment in clinics
16. Number of pneumothorax treatments in clinics
17. Other (specify)

D. MATERNITY SERVICE

1. Cases admitted to antepartum medical service
2. Cases admitted to antepartum nursing service
3. Visits by antepartum cases to medical conferences
4. Visits by antepartum cases to private physician

SHEET 3

D. MATERNITY SERVICE (Continued)

5. Field nursing visits to antepartum cases
6. Office nursing visits to antepartum cases
7. Cases attended by nurses for delivery service
8. Cases given postpartum medical examination
9. Cases given postpartum examination by private physicians
10. Cases admitted to postpartum nursing service
11. Nursing visits to postpartum cases
12. Number of maternity clinic sessions
13. Midwife meetings
14. Attendance at meetings
15. Visits for midwife supervision
16. Number of meetings of maternity classes
17. Attendance of maternity classes
18. Other (specify)

E. INFANT AND PRESCHOOL HYGIENE

Infants:

1. Individuals admitted to medical service
2. Individuals admitted to nursing service
3. Visits to medical conferences
4. Visits to private physicians
5. Field nursing visits
6. Office nursing visits
7. Other service (specify)

Preschool:

8. Individuals admitted to medical service
9. Individuals admitted to nursing service
10. Visits to medical conferences
11. Visits to private physicians
12. Field nursing visits

SHEET 4

E. INFANT AND PRESCHOOL HYGIENE (Continued)

13. Office nursing visits
14. Other service (specify)

Infant and Preschool:

15. Number of child health conference sessions
16. Number of meetings of infant and preschool classes
17. Attendance

F. SCHOOL HYGIENE

1. Examinations by physicians with parents present
2. Examinations by physicians with parents not present
3. Individuals admitted to nursing service
4. Field nursing visits
5. Office nursing visits
6. Other service (specify)

G. ADULT HYGIENE

Medical Examinations:

1. Milk-handlers
2. Other food-handlers
3. Midwives
4. Teachers
5. Other (specify)

H. FAMILY SERVICE

1. Families admitted to service
2. Number of visits to families
3. Other (specify)

SHEET 5

5
I. CRIPPLED CHILDREN'S SERVICE
1. Individuals admitted to medical service in clinics
2. Individuals admitted to nursing service
3. Visits to clinics
4. Field nursing visits
5. Office nursing visits
6. Other service (specify)
7. Individuals reported
J. GENERAL SANITATION
1. Approved individual water supplies installed
2. New privies installed - Total
3. New septic tanks installed
Field Visits:
4. Private premises
5. Camp sites
6. Swimming pools
7. Schools
8. Public water supplies
9. Other (specify)
10. Buildings mosquito proofed
11. Minor drainage - linear feet completed
12. Anopheles breeding places eliminated
13. Anopheles breeding places controlled
14. Sewer connection
15. Semi-public sewer connection
16. Connection to public water supply
17. Connection to semi-public water supply
K. PROTECTION OF FOOD AND MILK
1. Food-handling establishments registered for supervision

SHEET 6

6
K. PROTECTION OF FOOD AND MILK (Continued)
2. Field visits to food-handling establishments
3. Dairy farms registered for supervision
4. Field visits to dairy farms
5. Milk plants registered for supervision
6. Field visits to milk plants
7. Cows tuberculin tested
8. Other service (specify)
L. HEALTH EDUCATION
1. Scheduled classroom health talks
2. Attendance
3. Public lectures and talks
4. Attendance
5. Radio talks
6. Newspaper articles
7. Showing of films
8. Other (specify)
M. CANCER CONTROL
1. Individuals admitted to medical service
2. Individuals admitted for first time to nursing service
3. Individuals previously admitted given nursing service
4. Clinic visits
5. Field nursing visits to cases and suspected cases
6. Office nursing visits to cases and suspected cases
7. Admissions to hospital
<p style="text-align: right;">TENNESSEE DEPARTMENT OF PUBLIC HEALTH FORM 2</p>

PURPOSE: To code services rendered and to ensure uniformity of classification of activities, services and accomplishments.

EXPLANATION AND DEFINITIONS: Definitions of various terms used in code sheet will be found in Instructions for Preparation of Monthly Tabulation.

USED BY: All professional and field workers.

OFFICE MECHANICS AND FILING: Each worker has a set of code sheets in notebook with daily report blanks for reference.

11-3-47

INDEX CARD - FORM 3
SIZE 3" x 5"

FRONT

Name _____		
Last _____	First _____	
Address _____		
Date of Birth _____	Color _____	Sex _____
Father _____	Mother _____	
TYPE OF RECORD _____	WHERE FILED _____	

BACK

NAME _____	
LAST _____	FIRST _____
TYPE OF RECORD _____	WHERE FILED _____

TENNESSEE DEPARTMENT PUBLIC HEALTH NO. 3

PURPOSE: To provide a means of ready reference to basic records.

EXPLANATION AND DEFINITIONS:

Type of Record: As health, maternity, scarlet fever, typhoid fever, etc.

Where Filed: In this space is indicated where the record is, as "FF" or "FF #1." The number indicates the nursing district. When record is filed in family folder, the identification of the family should be recorded. In like manner when filed in other locations such as school, general preschool file, etc., sufficient information should be recorded so that record may be located.

The four spaces on the bottom and eight spaces on the back under "type of record" and "where filed" are provided so that both previous and current service may be recorded. An index card is made for each basic record: maternity, health, tuberculosis, communicable disease, etc. No index card is made for records of immunization, sanitation, or vital statistics; these records being arranged alphabetically, do not need further indexing.

USED BY: Personnel of health department.

OFFICE MECHANICS AND FILING: Routine for handling basic records provides that daily report sheet with records attached is routed each day to clerk for checking and filing. Before filing the clerk makes an index card for each new record.

PAY-ROLL - FORM 4
SIZE 8½" x 11"

FRONT

PAY-ROLL								
DEPARTMENT OF PUBLIC HEALTH--LOCAL HEALTH SERVICE								
OFFICE OF _____			HEALTH DEPARTMENT			MONTH OF _____, 19____		
BUDGET NO. _____								
POSITION NO.	NAME	TITLE	TIME IN DAYS		SALARY RATE PER MONTH	PAY-ROLL EARNINGS	AMOUNT PAID LOCALLY	AMOUNT PAID BY STATE VOUCHER
			WORK	ABSENT				
TOTAL								

MISSISSIPPI DEPARTMENT OF PUBLIC HEALTH NO. 4

BACK

THIS PAYROLL FOR \$_____ IS TRUE AND CORRECT.
THE TIME STATED WAS MADE AND THE SERVICES WERE RENDERED
FOR THE USE AND BENEFIT OF THE STATE.

(FOR CORRECTNESS) _____ CLERK

CERTIFIED _____ DIRECTOR

CODING: A - ANNUAL LEAVE
S - SICK LEAVE
O - LEAVE WITHOUT PAY

PAY-ROLL - FORM 4

PURPOSE: To provide for regular notification to the Central Office of the Tennessee Department of Public Health of the character, amount, rate, and cost of services of personnel performed monthly by each member of the staff of the local unit. When signed (for correctness) by the clerical worker responsible for the preparation of the pay-roll, and certified by the local health officer, the pay-roll serves as authorization for the payment of salaries.

EXPLANATION AND DEFINITIONS:

Position No.: Position number for each employee should be as furnished to the local unit by the Central Office.

Name: Names, as certified (i.e., if certified as Mrs. John Smith, should not be listed as Mary Smith), should be listed in numerical position order (1, 2, 2.1, 2.2, 3, 3.1, 3.2, 3.3, 4, etc.)

Title: Titles should be listed as certified (i.e., "Senior Medical Officer", not "Health Officer").

Time in Days: *Work* plus *absent* must total the number of days in the calendar month for which the pay-roll is submitted, except where services begin or terminate within the month, in which cases an explanation should be made. (For January, except as noted above, *work* plus *absent* must total 31; for February, 28; for March 31; etc.)

Work: include all days not charged as sick, annual, or without pay. This means that Sundays, holidays, and "other" leave *with* pay (for attendance at meetings, etc.), although included on the attendance record, should be carried on the pay-roll as days worked, since no leave (sick, annual, or without pay) is charged against the employee.

Absent: Sick leave, annual leave, and leave without pay should be ceded on the pay-roll thus:

- A - Annual leave
- S - Sick leave
- O - Leave without pay (MUST be explained).

All absences from duty on sick leave, annual leave, or leave without pay must be carried on pay-roll. Absences (sick, annual, or without pay) shown on the pay-roll for the current calendar month must agree with absences shown on the attendance record for the preceding month. **Exception:** Leave without pay, wherever possible, should be carried on the pay-roll for the month in which the leave is taken. (In all cases, computation of leave without pay is on the basis of the month in which the leave is taken. For example, deduction for leave without pay taken in January is 1/31, of the total salary for each day if leave without pay, for February, 1/28, etc.)

Salary Rate per Month: This is self-explanatory, except in the case of a salary part of which is paid *directly* to the employee from local sources and part by State check. In such a case the total rate should be listed; after it, a diagonal; after the diagonal, the amount paid by State check. **Example:** Miss Smith's total salary rate is \$170, of which \$150 is paid by State check; the remaining \$20 is paid to her directly from local sources. Salary rate to be shown on pay-roll: 170/150.

Pay-roll Earnings: This column should carry the amount due the employee after deductions for leave without pay, appointment within the month, or termination within the month.

Amount Paid Locally: If the total salary is paid *directly* from local sources, this column should carry the salary rate. In the case of Miss Smith (above), whose salary was at the rate of 170/150, the amount to be shown in this column is the difference between the

total amount earned and the amount to be paid by State check. If Miss Smith is paid a total of \$170, \$20 (170-150) should be carried in the column headed "Amount paid locally."

Amount Paid by State Voucher: Amount paid by State check should be shown here. In most instances, this figure will be the same as the figure in the column "Pay-roll earnings." In the case of Miss Smith (above), the amount shown in this column should be \$150.

USED BY: Health officer and clerical worker who prepares the pay-roll.

OFFICE MECHANICS AND FILING:

1. The pay-roll is prepared in duplicate by the clerical worker, who uses as a basis appointment, termination, or other personnel notices from the central office and leave records in the local unit office.
2. The pay-roll is signed on the back by the clerical worker (to indicate it has been checked for correctness) and is certified by the local health officer.
3. The original is transmitted to the office of the Director of Local Health Service (central office). The pay-roll, accompanied by the attendance record for the preceding month, *must*, in order to insure payment on time, *reach the State Office by the fifteenth of the month for which payment is made.*

Exceptions: a. Supplemental pay-rolls (submitted for various reasons, such as employment after regular pay-roll has been submitted, etc.). which should be transmitted to the State office at the earliest possible time.

b. Pay-rolls submitted on a reimbursement basis, which should reach the State office not later than the fifth of the month succeeding the calendar month for which payment is made. Pay-roll on a reimbursement basis must be accompanied by attendance record for the calendar month for which payment is made.

4. The copy of the pay-roll is retained in the files of the local unit.

NOTE: See instructions for preparation and submission of Monthly Attendance Record, Form 5.

SIZE 8½" x 11"

[illegible]

PURPOSE: To serve as a notification to the State office of days worked and days absent for each employee of a local health unit.

EXPLANATION AND DEFINITIONS:

Name: The names of all employees should be listed in alphabetical order, with last name first, for convenience in checking. The name on the attendance record should be exactly the same as that on the pay-roll (not "Mrs. John Smith" on one and "Bessie Smith" on the other).

Title: The titles should be listed exactly as shown on the pay-roll.

Spaces for days of the month: The blank spaces below the numbered spaces should be filled in with the proper day of the week, using X for Sunday. *Example:* If the month begins on Tuesday, the blocks under 1-7 will be filled as follows: 1, T; 2, W; 3, T; 4, F; 5, S; 6, X; 7, M.

Monthly Summary: The columns are self-explanatory.

Coding: Leave should be coded (in the block under the day on which it was taken) as follows:

- A - Annual leave
- S - Sick leave
- W - Special leave *with* pay
- O - Special leave *without* pay
- C - Cumulative leave
- H - Official holiday

Special leave with pay, special leave without pay, and cumulative leave *must be explained*. Cumulative leave (C) is used to record leave taken for having worked on a holiday; the holiday for which a day of cumulative leave is taken must be listed under "Remarks".

Half-days of leave should be coded by placing a diagonal in the center of the proper block, and placing code letters in upper or lower half of block to indicate a.m. or p.m.

USED BY: Health officer and clerical worker responsible for leave records and/or preparing pay-roll.

OFFICE MECHANICS AND FILING:

1. The monthly attendance record is prepared in triplicate by the clerical worker from leave records in the office of the local unit, and is signed by the health officer or director.

2. The original, together with the pay-roll for the succeeding month, is transmitted to the office of the Director of Local Health Service. It must reach the State office by the fifteenth of the calendar month for which the pay-roll is submitted. *No pay-roll will be passed for payment until the attendance record for the preceding month has been received.*

Exception; Attendance records for health departments which submit pay-rolls on a reimbursement basis are submitted with the pay-roll covering the same period (i.e., July Attendance record is submitted with July pay-roll, etc.), and must reach the State office by the fifth of the calendar month succeeding the month for which the attendance record is submitted.

3. One copy is transmitted to the Regional Office of Local Health Service; one copy is retained in the local health unit files.

NOTE: See instructions for the use of Pay-roll, Form 4.

Pages 6-8 missing

REQUISITION FOR SUPPLIES - FORM 9
SIZE 11" x 8½"

REQUISITION FOR SUPPLIES		
State Department of Public Health Nashville, Tenn.		
Send to.....		
Address.....		
.....		
BE SPECIFIC IN ORDERING		
Designation	Form No.	Amount
Date	Approved	
DO NOT WRITE BELOW THIS LINE		
Requisition received.....	Division.....	
Requisition filled.....	Sent by mail.....	
Requisition filled by.....	Sent by express.....	
TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 9		

PURPOSE: To provide simple and uniform requisition form.

EXPLANATION AND DEFINITIONS:

The spaces above second double line are used by the local health officer. The spaces below second double line are used by State Department of Health after requisition is received.

Designation: Refers to name of pamphlet, bulletin, or other supplies. When a record form is requested both the name and number are given.

OFFICE MECHANICS AND FILING: The requisition is made out by clerk at the request of person in charge of supplies needed. On approval of the health officer, the requisition is dated and mailed to State Department of Public Health. For laboratory supplies, requisitions are sent to the nearest branch laboratory. The items below the second double line are for use of supply room clerks, State Department of Public Health. To facilitate handling requisitions, separate requisitions should be prepared for each type of supplies or equipment.

COMMENTS: Health officers should foresee their needs so that "rush" orders may be reduced to a minimum.

VOUCHER FOR REIMBURSEMENT OF CONTINGENT EXPENSES - FORM 10
SIZE 11" x 8½"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 10									
STATE OF TENNESSEE									
Department of Public Health					VOUCHER FOR REIMBURSEMENT OF CONTINGENT EXPENSES				
Division					Unit				
(Code)									
This contingent account for the period from 194... to 194... in the sum of \$ is true and correct in all respects and the expense has been incurred in the service of the State.									
Position					Official Station				
Approved					Date				
Division Head									
Commissioner					Claimant				
Subscribed and sworn to before me this day of 194... Notary Public My Commission Expires									

PURPOSE: To provide for the submission of expense account in accordance with the budget classification requirements of the Division of Accounts of Tennessee.

EXPLANATION AND DEFINITIONS:

"Division" should be filled in with Local Health Service, Vital Statistics, etc., as applicable. After the word "Unit" should be typed the county name for local units or the section of service for accounts to be paid from divisions other than Local Health Service. Budget number should be added after the name of county. After the word "Code" the space should be left blank for the present. The items, "Position," "Official Station," and "Date" must be filled in. The individual submitting the account for reimbursement will sign as claimant and notarization will be entered in the space provided for that purpose. The division director and the commissioner will sign in the places provided for their signatures.

Accounts for reimbursement will not be accepted for less than a calendar month and it is preferred that one complete month only be covered.

The code numbers have been omitted from the column heads and are to be typed in at the time the claim is submitted. The procedure outlined above should be followed in submitting claims on this form. The budget classification must be rigidly adhered to in the submission of all claims.

In the first column below line should be entered the date of expenditure.

In the second column of blank are inserted the items for which funds have been expended or the name of the person or firm to whom money has been paid, indicating the receipt number of the attached receipt.

Columns left blank for insertion of numbers: In one or more of these columns is entered the amount or amounts expended for item set forth in second column of blank. The appropriate code or codes, is or are selected by reference to the following budget classification:

01. Salaries and wages
02. Per diems and fees
03. Supplies and materials
04. Printing and binding
05. Equipment
06. Communication
07. Travel
08. Motor vehicle operation
09. Publicity, subscriptions and dues
10. Rentals and insurance
11. Light, power, heat, water
12. Other service and expense
13. Maintenance and repairs
14. Awards, indemnities and extra -
15. Stores for resale or manufacture
16. Unclassified (specify descriptively)

USED BY: Health officer, nurses, sanitation officer, and clerk.

OFFICE MECHANICS AND FILING: This form is prepared in triplicate. Each of the triplicate copies must be accompanied by an itemized receipt for all items expended. Each receipt is assigned a number (as 1, 2, 3). All accounts are checked by clerk, all copies signed by field worker, and the original acknowledged before a notary public. After approval by the health officer, the original and one carbon are sent to the State Department of Health. A copy of the form is kept in local files. All purchases for \$5.00 or more must be requisitioned through the State Department of Public Health.

COMMENTS: Notary should place seal on right hand side including in the seal part of the signature of claimant. *Do not place seal on lines to be signed by Division Head and Commissioner.*

- Form DA-397-A is to be used in submitting claims for traveling expenses. This form must be completely filled out.
- Claims for traveling expenses are to be filed once a month unless otherwise specified by the Department of Accounts.
- Claims for traveling expenses authorized under Group Authorizations must be filed with the Department of Accounts at the same time.
- A separate claim for traveling expenses must be filed by each claimant.
- Items other than actual traveling expenses cannot be made a part of the claim for traveling expenses.
- Tips will not be allowed, except where there is a need, in which case a full and satisfactory explanation must be given.
- Receipts are required for all items in excess of one dollar (\$1.00).
- Telephone calls and telegrams will not be allowed unless a full and satisfactory explanation is shown and reason for call or telegram satisfactorily explained.
- Heads of Departments with the approval of the Director of Accounts may authorize the payment of travel expenses if provided this amount does not conflict with any of the above regulations.
- Items of traveling expenses not covered in the above regulations must be accompanied by a satisfactory explanation.

CLAIM FOR TRAVELING EXPENSES - FORM DA - 307-A (FORM 11)

PURPOSE: To provide for the submission of expense accounts in accordance with the requirements of the *Department of Accounts of Tennessee*.

EXPLANATION AND DEFINITIONS:

Travel Authorization Number: The State Department of Public Health is responsible for procuring this authorization and the number will be added in the central office.

Division and Unit: The correct division, budget and item number should be entered.

For Period From: Calendar month covered.

Date: Give first and last dates of month.

Place Left, Time Left, Place Arrived and Time Arrived: In part or all of these columns the local personnel should write "County Travel," except when subsistence is claimed, in which case the necessary information in all of these columns should be given.

Mileage Amount: Give total amount for the month at six cents per mile.

Other items will be classified as indicated. The totals shown under "Mileage Amount" and "Other Expenses," and any other items used should be totaled and the amount entered in the proper space.

As explanation of the use of cars by local personnel, the following statement is suggested: "Local travel--no other means of travel available." Accounts for a month should be in the central office on or before the 5th of the following month.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: This form is prepared in triplicate, the original and one copy are submitted to the central office, and the other copy is kept in the local health department. Each of these copies must be accompanied by a Daily Mileage Sheet (See instructions for Form 12). All accounts are checked by the clerk and the person submitting the account. The claimant must sign in the proper space and the health officer should approve the account in the body of the record. *The Commissioner of Public Health will sign on the line where form reads "Approved."*

CORRECTIONS TO REGULATIONS - TRAVELING EXPENSES

SUBSISTENCE

11. The maximum subsistence allowance within the State is five dollars (\$5.00) per day except in cities over 100,000, where six dollars (\$6.00) per day will be allowed, if explained.

TRANSPORTATION

19. When the use of personal cars for State business is authorized, a mileage rate of six (6¢) per mile will be allowed.
26. Bridge tolls have been eliminated.

OTHER

30. Form DA-307-A (Form 11) is to be used in submitting claims for traveling expenses. This form must be completely filled out and submitted in duplicate.
40. The State is not subject to Federal tax. Tax exemption certificates for transportation may be secured at the central office.
41. The State is exempt from the payment of the sales tax. Exemption certificates have been issued by the Commissioner of Finance and Taxation and may be secured upon request.

11-3-47

DAILY MILEAGE SHEET - FORM 12
SIZE 4¼" x 7¼"

FRONT

[illegible]

BACK

[illegible]

DAILY MILEAGE SHEET - FORM 12

PURPOSE: For daily record of official mileage and as basis for monthly expense account, Form DA 307-A (Form 11).

EXPLANATION AND DEFINITIONS:

Places Visited: Wherever possible the actual point visited should be given, but when several points in a given community are visited the vicinity visited may be given. For example: "Sneedville area."

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: These sheets fit into a loose leaf notebook with Daily Report sheets and Code for Daily Reports, and are carried into the field. On the first of each month, they will be given to the clerk for copying and preparation of Claim for Traveling Expenses, Form DA 307-A (Form 11). Total mileage shown for each day will be entered on expense account.

11-3-47

Pages 13-14 missing

REQUEST FOR LEAVE OF ABSENCE - FORM 15
 SIZE 11" x 8½"

REQUEST FOR LEAVE OF ABSENCE	
Name	Date
Division of	
I request leave of absence* fordays from to inclusive.	
Signed..... Title.....	
Recommended: Date By Approved: Date By	
*Supply word: Annual, Sick, Without pay, or Other.	
Address while absent will be.....	
<small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 15</small>	

PURPOSE: To provide a record for use locally of leave requested by county health department personnel.

EXPLANATIONS AND DEFINITIONS: Items are self-explanatory.

USED BY: County health department personnel.

OFFICE MECHANICS AND FILING:

A request for leave of absence by the nurse, sanitarian, clerk or other local health department personnel except the health officer, is submitted to the health officer for his approval. After approval, the request is filed by the clerk and used to check the availability of leave of each member. A notification of all sick and annual leave of the above personnel is sent to the Department of Public Health by letter.

Requests for all annual leave and leave without pay for the health officer are signed by the appointing authority (Chairman of County Board of Health, County Judge, City or County Commissioner as indicated), and mailed in duplicate to the State Department of Public Health, preferably a month ahead of time. A third copy is kept in the local health depart-

ment files. A request for sick leave for the health officer is made in triplicate the day the health officer returns to work, and the original and one copy mailed to the State Department of Public Health. The third copy is kept in the local files. (In counties temporarily without service of a director other personnel should follow procedure outlined for the health officer.)

Requests for all leave without pay, for both health officer and other personnel, are mailed to the State Department of Public Health in duplicate well ahead of the time the leave is to be taken, if possible. The Regional office should be notified of all leave in advance, if possible.

This information is needed to correct pay-rolls that may have been released to the State Director of Accounts and State Director of Personnel for payment.

11-8-47

YEARLY ATTENDANCE SUMMARY CARD - FORM 16
SIZE 5" x 8"

YEARLY ATTENDANCE SUMMARY CARD																											
NAME _____																											
DEPARTMENT _____		POSITION _____																									
YEAR _____																											
TYPE LEAVE	ANNUAL			SICK			OTHER			ANNUAL			SICK			OTHER			ANNUAL			SICK			OTHER		
	Accumulated	Taken		Accumulated	Taken		Accumulated	Taken		Accumulated	Taken		Accumulated	Taken		Accumulated	Taken		Accumulated	Taken		Accumulated	Taken				
JANUARY																											
FEBRUARY																											
MARCH																											
APRIL																											
MAY																											
JUNE																											
JULY																											
AUGUST																											
SEPTEMBER																											
OCTOBER																											
NOVEMBER																											
DECEMBER																											
REMARKS:																											

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 16

PURPOSE: To provide a record of the amount and type of leave accumulated and taken by local health department personnel.

EXPLANATION AND DEFINITIONS:

Type of Leave: Annual, sick, and other.

Other Leave: This includes all leave other than annual and sick; leave without pay, military leave, cumulative leave, etc. This "other" leave should be specified under "remarks."

Accumulated: These columns show the amount of annual and sick leave accumulated through the last day of a particular month. An employee must be on the pay-roll for the greater portion of a month before annual and sick leave is to be accumulated.

Taken: These columns show the amount of annual and sick leave taken during one particular month.

USED BY: Health officer and clerk.

OFFICE MECHANICS AND FILING: In determining the amount of sick leave accumulated for a given month, the amount of sick leave taken during the previous month is subtracted from the amount of sick leave accumulated by the end of the previous month, and this total added to the one day of sick leave accumulated during the given month. *For example:* Mary Doe, clerk, was employed the first day of January. At the end of January she had accumulated one day of sick leave. By the end of February she had accumulated two days of sick leave, and by the end of March she had accumulated three days of sick leave; but during March she took two days of sick leave. This makes the figure on the March column (see following table) "sick accumulated" 3, and "sick taken" 2. The amount of sick leave accumulated at the end of April would be 2 (3-2 = 1).

Type Leave	Annual		Sick		Other
	Accu- mulated	Taken	Accu- mulated	Taken	Taken
January	1		1		
February	2		2		
March	3		3	2	
April	4		2		

Accumulated annual leave is determined on the same basis as the above.

Accumulated, annual and sick leave is carried over from December to January of the next year in the same manner as from January to February.

The data for these cards are taken from the monthly attendance record, and a card is kept for each employee. They are filed alphabetically in a 5" x 8" file. If an employee transfers to another county, the health officer of that county may request a copy of the attendance summary.

Latest regulations governing leave (as issued by the Tennessee Department of Public Health) should be referred to in determining eligibility for leave and any other questions as they arise.

11-3-47

Page 17 missing

PURPOSE: To provide a confidential report of the efficiency of each employee of the Tennessee Department of Public Health for use in planning of promotions, salary increases, training and evaluation of personnel.

METHOD: Reports are required at the end of the first six months of employment. If a change of status to a new position is made, a report should be submitted at the end of the first six months in the new position. After the initial report in the probationary period reports should be completed annually; namely, at 18 months, 30 months, etc.

EVALUATION BY SUPERVISOR OR CONSULTANT:

State Health Department: In the State Health Department, the evaluation will usually be made by a service or division director. If employee works under another person in a large division, this immediate supervisor should complete evaluation.

Local Health Departments: In local health departments, if responsibility has been delegated to a supervisor or head of a division these persons should be responsible for the evaluations of employees working under them. The nursing supervisors must be of at least junior consultant rating. In local health departments without technical supervisory personnel, the evaluations should be completed through consultant service from State level in cooperation with the health officer; that is, the field consultant nurse should complete for the nurse, the field sanitarian for the sanitarian, the clerical assistant for the clerk, etc. The evaluation of the director of a local health department should be completed by a medical officer of Local Health Service.

RECOMMENDATIONS - DIRECTOR OR OTHERS IN CHARGE:

State Health Department: In the State Health Department if the evaluation is made by a service director, this section will be completed by the division director or the next person in charge (for Central Administration, this would be the Commissioner).

Below the section for recommendations is a space for comments of the Commissioner or others in charge.

Local Health Departments: The director of the local health department should complete the recommendations of all persons of his staff after completion of evaluation by supervisors or in lieu of supervisors, field consultants.

The comments of others in charge; that is, of the director of the field technical staff of Local Health Service, supervisory nurse and Commissioner would be added in the space provided below recommendations, at the bottom of the record.

REMARKS: Under remarks, unusual abilities should be recorded with remarks concerning potentialities, future training, etc. Any unusual circumstances or vices that tend to lower the quality of work should be reported. Lack of self control, bad temper, or any other weaknesses of sufficient importance to be classed as damaging should be included.

COMMENTS: The appraiser should be careful in his grading of personnel. In the overall picture of the State, approximately half of the employees in a given grade would be average with relatively small proportions above average and superior and below average and inferior. Care and judgment on the part of the appraiser are required to estimate properly an employee's ability. The appraisal of the appraiser will be based to some extent on his ability to rate others.

MONTHLY TABULATION - FORM 19
SIZE 11" x 8½"

SHEET 1

MONTHLY TABULATION

CITY, COUNTY OR DISTRICT _____

MONTH _____ YEAR _____

	TOTAL THIS MONTH	TOTAL THIS YEAR
A. COMMUNICABLE DISEASE CONTROL		
1. ADMISSIONS TO SERVICE _____		
2. CONSULTATIONS WITH PHYSICIANS _____		
FIELD VISITS (CASES, SUSPECTS, AND CARRIERS):		
3. DIPHTHERIA _____		
4. TYPHOID FEVER AND PARATYPHOID FEVER _____		
5. SCARLET FEVER _____		
6. SMALLPOX _____		
7. MEASLES _____		
8. WHOOPING COUGH _____		
9. VENEREAL DISEASES _____		
10. OTHER (SPECIFY) _____		

IMMUNIZATIONS (PERSONS IMMUNIZED):		
11. SMALLPOX (INCLUDING REVACCINATIONS) _____		
12. DIPHTHERIA - UNDER 1 YEAR _____		
13. DIPHTHERIA - 1 YEAR _____		
14. DIPHTHERIA - 2 YEARS _____		
15. DIPHTHERIA - 3 YEARS _____		
16. DIPHTHERIA - 4 YEARS _____		
17. DIPHTHERIA - 5 YEARS AND OVER _____		
18. TYPHOID FEVER _____		
19. WHOOPING COUGH - UNDER 1 YEAR _____		
20. WHOOPING COUGH - 1 YEAR _____		
21. WHOOPING COUGH - 2 YEARS AND OVER _____		
22. OTHER (SPECIFY) _____		

B. DENTAL HYGIENE		
1. PRESCHOOL INSPECTIONS _____		
2. PRESCHOOL INDIVIDUALS ADMITTED _____		
3. PRESCHOOL OPERATIONS _____		
4. PRESCHOOL INDIVIDUALS COMPLETED _____		
5. SCHOOL INSPECTIONS _____		
6. SCHOOL INDIVIDUALS ADMITTED _____		
7. SCHOOL OPERATIONS _____		
8. SCHOOL INDIVIDUALS COMPLETED _____		
9. OTHER (SPECIFY) _____		

SHEET 2

2

	TOTAL THIS MONTH	TOTAL THIS YEAR
C. TUBERCULOSIS CONTROL		
1. INDIVIDUALS ADMITTED TO MEDICAL SERVICE _____		
2. CASES ADMITTED FOR FIRST TIME TO NURSING SERVICE _____		
3. CASES PREVIOUSLY ADMITTED GIVEN NURSING SERVICE _____		
4. CONTACTS AND SUSPECTED CASES ADMITTED TO NURSING SERVICE _____		
5. X-RAY EXAMINATIONS OF CASES _____		
6. X-RAY EXAMINATIONS OF CONTACTS _____		
7. X-RAY EXAMINATIONS OF OTHERS _____		
8. CLINIC VISITS _____		
9. VISITS TO PRIVATE PHYSICIANS _____		
10. FIELD NURSING VISITS TO CASES _____		
11. FIELD NURSING VISITS TO OTHERS _____		
12. OFFICE NURSING VISITS TO CASES _____		
13. OFFICE NURSING VISITS TO OTHERS _____		
14. ADMISSIONS TO SANATORIA _____		
15. PATIENTS ADMITTED FOR PNEUMOTHORAX TREATMENT IN CLINICS _____		
16. NUMBER OF PNEUMOTHORAX TREATMENTS IN CLINICS _____		
17. OTHER (SPECIFY) _____		
D. MATERNITY SERVICE		
1. CASES ADMITTED TO ANTEPARTUM MEDICAL SERVICE _____		
2. CASES ADMITTED TO ANTEPARTUM NURSING SERVICE _____		
3. VISITS BY ANTEPARTUM CASES TO MEDICAL CONFERENCES _____		
4. VISITS BY ANTEPARTUM CASES TO PRIVATE PHYSICIAN _____		
5. FIELD NURSING VISITS TO ANTEPARTUM CASES _____		
6. OFFICE NURSING VISITS TO ANTEPARTUM CASES _____		
7. CASES ATTENDED BY NURSES FOR DELIVERY SERVICE _____		
8. CASES GIVEN POSTPARTUM MEDICAL EXAMINATION _____		
9. CASES GIVEN POSTPARTUM EXAMINATION BY PRIVATE PHYSICIAN _____		
10. CASES ADMITTED TO POSTPARTUM NURSING SERVICE _____		
11. NURSING VISITS TO POSTPARTUM CASES _____		
12. NUMBER OF MATERNITY CLINIC SESSIONS _____		
13. MIDWIFE MEETINGS _____		
14. ATTENDANCE AT MEETINGS _____		
15. VISITS FOR MIDWIFE SUPERVISION _____		
16. NUMBER OF MEETINGS OF MATERNITY CLASSES _____		
17. ATTENDANCE OF MATERNITY CLASSES _____		
18. OTHER (SPECIFY) _____		
E. INFANT AND PRESCHOOL HYGIENE		
INFANTS:		
1. INDIVIDUALS ADMITTED TO MEDICAL SERVICE _____		
2. INDIVIDUALS ADMITTED TO NURSING SERVICE _____		
3. VISITS TO MEDICAL CONFERENCES _____		
4. VISITS TO PRIVATE PHYSICIANS _____		
5. FIELD NURSING VISITS _____		
6. OFFICE NURSING VISITS _____		
7. OTHER SERVICE (SPECIFY) _____		

SHEET 3

3

	TOTAL THIS MONTH	TOTAL THIS YEAR
INFANT AND PRESCHOOL HYGIENE (CONTINUED)		
PRESCHOOL:		
8. INDIVIDUALS ADMITTED TO MEDICAL SERVICE _____		
9. INDIVIDUALS ADMITTED TO NURSING SERVICE _____		
10. VISITS TO MEDICAL CONFERENCES _____		
11. VISITS TO PRIVATE PHYSICIANS _____		
12. FIELD NURSING VISITS _____		
13. OFFICE NURSING VISITS _____		
14. OTHER SERVICE (SPECIFY) _____		
INFANT AND PRESCHOOL:		
15. NUMBER OF CHILD HEALTH CONFERENCE SESSIONS _____		
16. NUMBER OF MEETINGS OF INFANT AND PRESCHOOL CLASSES _____		
17. ATTENDANCE _____		
F. SCHOOL HYGIENE		
1. EXAMINATIONS BY PHYSICIANS WITH PARENTS PRESENT _____		
2. EXAMINATIONS BY PHYSICIANS WITH PARENTS NOT PRESENT _____		
3. INDIVIDUALS ADMITTED TO NURSING SERVICE _____		
4. FIELD NURSING VISITS _____		
5. OFFICE NURSING VISITS _____		
6. OTHER SERVICE (SPECIFY) _____		
G. ADULT HYGIENE		
MEDICAL EXAMINATIONS:		
1. MILK-HANDLERS _____		
2. OTHER FOOD-HANDLERS _____		
3. MIDWIVES _____		
4. TEACHERS _____		
5. OTHER (SPECIFY) _____		
H. FAMILY SERVICE		
1. FAMILIES ADMITTED TO SERVICE _____		
2. NUMBER OF VISITS TO FAMILIES _____		
3. OTHER (SPECIFY) _____		
I. CRIPPLED CHILDREN'S SERVICE		
1. INDIVIDUALS ADMITTED TO MEDICAL SERVICE IN CLINICS _____		
2. INDIVIDUALS ADMITTED TO NURSING SERVICE _____		
3. VISITS TO CLINICS _____		
4. FIELD NURSING VISITS _____		
5. OFFICE NURSING VISITS _____		
6. OTHER SERVICE (SPECIFY) _____		
7. INDIVIDUALS REPORTED _____		

SHEET 4

4

	TOTAL THIS MONTH	TOTAL THIS YEAR
J. GENERAL SANITATION		
1. APPROVED INDIVIDUAL WATER SUPPLIES INSTALLED		
2. NEW PRIVIES INSTALLED - TOTAL		
3. NEW SEPTIC TANKS INSTALLED		
FIELD VISITS:		
4. PRIVATE PREMISES		
5. CAMP SITES		
6. SWIMMING POOLS		
7. SCHOOLS		
8. PUBLIC WATER SUPPLIES		
9. OTHER (SPECIFY)		
10. BUILDINGS MOSQUITO PROOFED		
11. MINOR DRAINAGE - LINEAR FEET COMPLETED		
12. ANOPHELES BREEDING PLACES ELIMINATED		
13. ANOPHELES BREEDING PLACES CONTROLLED		
14. SEWER CONNECTION		
15. SEMI-PUBLIC SEWER CONNECTION		
16. CONNECTION TO PUBLIC WATER SUPPLY		
17. CONNECTION TO SEMI-PUBLIC WATER SUPPLY		
K. PROTECTION OF FOOD AND MILK		
1. FOOD-HANDLING ESTABLISHMENTS REGISTERED FOR SUPERVISION		
2. FIELD VISITS TO FOOD-HANDLING ESTABLISHMENTS		
3. DAIRY FARMS REGISTERED FOR SUPERVISION		
4. FIELD VISITS TO DAIRY FARMS		
5. MILK PLANTS REGISTERED FOR SUPERVISION		
6. FIELD VISITS TO MILK PLANTS		
7. COWS TUBERCULIN TESTED		
8. OTHER SERVICE (SPECIFY)		
L. HEALTH EDUCATION		
1. SCHEDULED CLASSROOM HEALTH TALKS		
2. ATTENDANCE		
3. PUBLIC LECTURES AND TALKS		
4. ATTENDANCE		
5. RADIO TALKS		
6. NEWSPAPER ARTICLES		
7. SHOWING OF FILMS		
8. OTHER (SPECIFY)		
M. CANCER CONTROL		
1. INDIVIDUALS ADMITTED TO MEDICAL SERVICE		
2. INDIVIDUALS ADMITTED FOR FIRST TIME TO NURSING SERVICE		
3. INDIVIDUALS PREVIOUSLY ADMITTED GIVEN NURSING SERVICE		
4. CLINIC VISITS		
5. FIELD NURSING VISITS TO CASES AND SUSPECTED CASES		
6. OFFICE NURSING VISITS TO CASES AND SUSPECTED CASES		
7. ADMISSIONS TO HOSPITAL		

DEFINITIONS AND INSTRUCTIONS FOR MONTHLY TABULATION

DEPARTMENT SERVICES

FORM 19

GENERAL DIRECTIONS

PURPOSE OF FORM: The tabulation form to which these instructions and definitions apply is devised for use by local health departments in summarizing services. The items appearing on the form are considered necessary for describing the services.

Space has been left under "Other" in each item for health departments to include activities not listed on the report.

REPORT YEAR: The calendar year is recommended as the report year. For purposes of tabulation, each year is treated as a unit, and the enumeration is begun anew with the first service rendered. A person who is under care, supervision, or instruction at the close of one year and who is carried over into the following year or who returns at any time during the following year is considered new and should be counted again. The principle just described also applies to premises under sanitation service.

ENUMERATION OF INDIVIDUALS AND PREMISES: When either of the terms individuals or premises appears on the tabulation form, the service described is presumed to continue, perhaps with interruptions, during the year. Under these circumstances an individual or premise should be counted only once during the year as the recipient of a given type of service.

ENUMERATION OF CASES AND ADMISSIONS: For cases and admissions the condition rather than the individual is the basis of enumeration. If a person should be admitted for a condition which terminates, such as acute illness, pregnancy, etc., and should apply for the same service or a different service within the same year, that person is readmitted and counted a second time.

ENUMERATION OF INDIVIDUALS SEEN IN GROUPS: Unless a case record is made for an individual receiving service through group activities, he is not considered as an individual admitted to service.

ENUMERATION OF PROCEDURES: Visits, inspections, examinations, treatments, and similar procedures are to be enumerated on the basis of each service when it is rendered in keeping with the following circumstances:

A service is counted if it is rendered by an individual with professional training required for performing the service. An actual contact by the worker must be made and service must be performed. A service may be recorded for indirect contact in the case of parent seen in behalf of a child, or if a case is not investigated until after death, or under other circumstances where the purpose of the visit is accomplished. An actual entry of the service must be made on a case or premise record.

A single call at a home is to be counted as one visit if service is rendered to only one person, as two visits if two persons are served, and so on, provided an entry is made on the record of each individual. A service to a child in school is not recorded as a field visit.

A contact with an individual where two or more types of service are performed is to be recorded only one time according to the primary purpose of the visit. If a chronic or

continuing condition is complicated by an acute condition, then the individual preferably is classed as admitted to service for the acute condition.

When two staff members participate in a given service, the service is entered on the tabulation by one member only, preference being given to the staff member performing the major service.

As a general rule, the premises form the basis for enumerating field visits. However, when the visit involves premises with several utilities, such as a hotel having a restaurant, a barber shop, and a swimming pool, or such as an amusement park having numerous concessions, a separate report is made of each utility seen for a definite purpose and each contact is counted as a separate visit.

The tabulation is intended to include a limited number of services which are complementary to the program of the health department, such as designated activities of private physicians and hospitalization of tuberculosis cases. These services are to be included irrespective of where budgetary and administrative responsibility may be. When a private physician participates under direction in a program which is administered by the health department, his service is recorded in the same manner as prescribed for a medical officer. A service of a physician to a private patient may be included where indicated on the tabulation form (visits to private physicians) provided an entry of the service is made on the record of the individual served and is filed in the health department. As a rule, these individuals will be receiving some service, commonly nursing, from the health department.

USE OF COLUMNS: The two columns following the items of service are so arranged that the form is adaptable to tabulations or reports for various periods, total for this month, and total for this year.

EDUCATIONAL SERVICES: A public lecture or a talk means the orderly presentation of information to a group. A classroom health talk is not to be included, as this type of instruction is an integral part of the school health program and should be tabulated separately. Attendance should be computed as accurately as possible.

A health class is more formal in character than a lecture or a talk. The term *class* implies that a definite number of individuals have agreed to pursue a course of instruction extending over a specified number of sessions. *Attendance* is the sum of the number present at each session during the period covered by the report.

MEDICAL CONFERENCES: A medical conference may be described as a consultation of an individual with a physician in the health department office or in a field station. A visit to a private physician does not fall in this category.

SPECIFIC ITEMS

All items appearing in the monthly tabulation are not included in the definitions which follow. The items selected for definitions are representative of activities common to a number of services.

A. COMMUNICABLE DISEASE CONTROL

1. *Admissions to service* include persons who are ill with communicable disease, who are suspected of having communicable disease, or who are carriers of the causative organism, provided these persons are seen by the health department for purposes of care or control. Those receiving immunization services only are not counted under this item.

2. *Consultations with physicians* are visits by health department physicians to patients under the care of private physicians for purposes of assisting in the establish-

ment of diagnoses or of giving professional advice of any type to the physicians in charge of the cases.

3-10. *Field visits*, with the exception of those for venereal disease (9), refer only to those made by the health department to diagnosed or suspected cases and carriers.

Field visits for venereal diseases (9) include all visits by the health department for purpose of control or care of diagnosed or suspected cases and contacts.

11-22. *Immunizations* refer to those persons who received the approved dosage of the appropriate agent for active immunization. For the purposes of counting individuals immunized, one dose of diphtheria toxoid should be counted as an immunization even though two doses should be given. If more than one injection is required, the person should not be counted until the series is completed. Immunization service may be recorded when the work is performed by the health department or when performed by other agencies provided pertinent facts are entered in the health department record.

B. DENTAL HYGIENE - Services rendered by dentists and dental hygienists.

2, 6. *Individuals admitted to dental service* are persons admitted for preventive and corrective dentistry to facilities of the health department (including those admitted in the cooperative dental program).

3, 7. *Operations* include both preventive and corrective dental services of the health department, such as prophylaxis, extractions, fillings, and other treatments.

4, 8. *Individuals completed* are those who have received all the needed dental care.

C. TUBERCULOSIS CONTROL

1. *Individuals admitted to medical service* are those admitted to routine x-ray clinics.

2. *Cases admitted for first time to nursing service* are those admitted for the first time usually because they are newly diagnosed cases or cases moved into the area. A diagnosed case has definite reinfection type tuberculosis or active significant first infection type lesion with positive tuberculin reaction.

3. *Cases previously admitted given nursing service* are cases admitted in a previous year who are given nursing service for first time during current year.

4. *Contacts and suspected cases admitted to nursing service* include all individuals except diagnosed cases in 2 and 3 admitted to tuberculosis nursing service. Contacts may be included if they are under active supervision and if definite service is rendered during the visits.

5, 6, 7. *X-ray examinations in routine x-ray clinics* are divided according to reason for examination - case, contact, or other. A *contact* is an individual in close association with a diagnosed case of tuberculosis. Examinations of children, siblings and parents of cases are to be included under 6.

8. *Clinic visits* include visits for diagnosis and/or treatment in health department facilities.

10, 11, 12, 13. *Field nursing visits and office nursing visits* refer to visits in the field or in the office to individuals admitted in 2, 3(cases), and 4(others).

14. *Admissions to sanatoria* include all residents of the area who have tuberculosis and are admitted to any hospital or sanatorium either in the area or outside of the area irrespective of the agency or person responsible for admission of the patient.

15. *Patients admitted for pneumothorax treatment in clinics* can be completed only in certain counties in which pneumothorax clinics are held. All patients admitted from other counties as well as those from the county in which treatments are given should be included.

16. *Number of pneumothorax treatments in clinics* includes the treatments, (refills and aspirations) to patients in 15.

Items 15 and 16 are to be completed only in counties with pneumothorax clinics. Patients admitted to pneumothorax clinics will include some patients who are residents of other counties. These services will be rendered in the counties where clinics are held.

D. MATERNITY SERVICE

1. *Cases admitted to antepartum medical service* include only those given services by the health department where a physician is in attendance. Partial services, such as urinalysis or blood pressure reading, by non-medical attendants are not counted under this item.

6. *Office nursing visits by antepartum cases* apply to the visits of antepartum cases to the health department nurses, in which individual advisory services are rendered.

10. *Cases admitted to postpartum nursing service* should include those previously under antepartum care by health department nurses as well as those admitted for postpartum care only.

12. *Number of maternity clinic sessions* includes all sessions conducted under the administration or supervision of the health department. A session is equivalent to one-half day.

13. *Midwife meetings* are less formal in character than midwife classes. A staff member of the health department or some other person approved by the health officer must preside at each meeting.

15. *Visits for midwife supervision* are visits made by or to members of the health department for the purpose of supervision of the practice of individual midwives.

E. INFANT AND PRESCHOOL HYGIENE

An *infant* is a child under one year of age.

A *preschool child* is a child between one and six years of age who is not attending school. A child under six years of age in a nursery school or kindergarten is counted as a preschool child.

A child under continuous health supervision but passing from one age group to another during a report year is counted once as an infant and once as a preschool child.

1, 8. *Infants and preschool children admitted to medical service* include only those receiving services given to infants and preschool children through facilities of the health department where physicians are in attendance.

2, 9. *Infants and preschool children admitted to nursing service* include all infants and preschool children seen by nurses of the health department in the interest of health supervision.

6, 13. *Office nursing visits* are those of infants and preschool children to health department nurses, in which individual advisory services are rendered.

15. *Number of child health conference sessions* includes all sessions conducted under

the administration or supervision of the health department. A session is equivalent to one-half day.

F. SCHOOL HYGIENE

For the purpose of classifying service to children, a *school child* is considered to be one six years of age and under fifteen or one fifteen years and over who is attending school.

Examinations by physicians are the more formal types of examinations given by the health department at stated periods during school life to determine physical status or examinations of children referred for special reasons.

1. Examinations by physicians with parents present are those which are made in the presence of parents (father, mother, or guardian), thus affording an opportunity for the physicians to discuss the findings with the parents.

G. ADULT HYGIENE

In this section are to be posted the number of physical examinations made by health department physicians of persons engaged in occupations where freedom from certain diseases is required by the health authorities. Laboratory tests or interim inspections for specific communicable diseases should not be recorded in this section. The number of examinations rather than the number of individuals forms the basis of enumeration.

H. FAMILY SERVICE

1. Families admitted to service are admissions to family service (admitted at the time of the first visit in each calendar year).

2. Number of visits to families are visits to families (not individuals).

I. CRIPPLED CHILDREN'S SERVICE

Unless otherwise specified by state law, a *child* is defined for the purpose of tabulation as any person under 21 years of age having orthopedic or other types of disabilities.

1. Individuals admitted to medical service in clinics are individuals receiving diagnostic or treatment service, in connection with a crippling condition, at health department clinic or elsewhere, if by arrangement of health department.

6. Other service is intended for the separate listing of visits or other services by physiotherapists, social workers, and nutritionists if rendered by the health department.

J. GENERAL SANITATION

1, 2, 3. Approved individual water supplies installed, new privies installed, and new septic tanks installed include those sanitary improvements made by or induced by the health department. However, it must be understood that those items relate to new construction of individual water supplies and excreta disposal facilities which are not connected with the public system.

4-9. Field visits include all visits by the health department personnel in the interest of sanitation. As was pointed out in "Enumeration of Visits," the premises usually forms the basis of enumeration. However, in the case of premises such as a hotel or an amusement park where several utilities are operated, a separate entry is made on the record of each utility seen for a definite purpose and each contact is counted as a separate visit.

10. *Buildings mosquito proofed* refer to buildings where people congregate or reside which the health department has been instrumental in making mosquito proof by screening with 16 mesh wire and by stoppage of cracks and holes through which mosquitoes might enter.

12. *Anopheles breeding places eliminated* refer to depressions where water normally collected and which the health department has succeeded in having filled or drained for the purpose of permanently preventing the breeding of *Anopheles* mosquitoes.

13. *Anopheles breeding places controlled* refer to natural and artificial collections of water which through the efforts of the health department have been treated with approved larvicides for the purpose of preventing breeding of *Anopheles* mosquitoes.

15, 17. *Semi-public* is used in referring to a small privately owned sewerage system of water system supply serving more than one family.

K. PROTECTION OF FOOD AND MILK

1. *Food-handling establishments registered for supervision* comprise the number of places at which food or beverages are produced, processed, or dispensed, and over which the health department regularly exercises a sanitary control. Establishments can be registered but once during report year and then only if complete surveys of the premises are made and the findings are recorded.

3. *Dairy farms registered for supervision* include only farms producing milk under provision of milk regulations or ordinances and receiving at least one complete inspection by the health department during the report year.

5. *Milk plants registered for supervision* are to be considered in the same manner as "Food-handling establishments." The term "milk plants" applies to pasteurizing plants, milk depots, and other similar places.

7. *Cows tuberculin tested* are cows tested by licensed veterinarians when testing is required by the local milk ordinances.

M. CANCER CONTROL

1. *Individuals admitted to medical service* are those who have been diagnosed as having cancer, or who are suspected to have cancer, providing these persons are seen at stated scheduled clinics conducted by physicians for the purpose of cancer control.

2. *Individuals admitted for first time to nursing service* are persons with cancer or suspected cancer admitted for the first time.

3. *Individuals previously admitted given nursing service* are persons with cancer or suspected cancer admitted in a previous year who are given nursing service for first time during current year.

4. *Clinic visits* include visits for diagnosis and/or treatment to individuals admitted in 1.

5, 6. *Field nursing visits to cases and suspected cases and office nursing visits to cases and suspected cases* refer to visits in the field or in the office to individuals admitted in 2 and 3.

7. *Admissions to hospital* include all residents of the area who are admitted for diagnostic and/or treatment services to any hospital either in the area or outside of the area irrespective of the agency or person responsible for admission of the patient.

Pages 20-23 missing

MONTHLY BALANCE SHEET - FORM 24
SIZE 11" x 8½"

[illegible]

PURPOSE: To provide a monthly check on program balance and trend. May be used for individual workers and also for total performance by groups - nursing, sanitation, health education, etc.

EXPLANATION AND DEFINITIONS: The item headings and standards may be any that the health officer and workers select. It is suggested that vital statistics and morbidity statistics for a five-year period and other data regarding local problems be used as guides. The standard is the annual quota divided by twelve to show what should be accomplished each month. The space under month and opposite each item is divided into two triangles. The upper triangle is for the service actually performed to date, and the lower for the quota to date.

USED BY: All workers.

OFFICE MECHANICS AND FILING: At the end of the month, the summaries of dailies may be rendered on these balance sheets.

COMMENT: Use entirely optional. The attached sample is shown on calendar and not fiscal year. It may be modified.

Pages 25-99 missing

CERTIFICATE OF LIVE BIRTH - FORM 100
SIZE 7½" x 9"

<p><small>THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND WILL BE PLACED IN PERMANENT FILE.</small></p> <p><small>WRITE PLAINLY WITH PERMANENT INK OR TYPEWRITER.</small></p> <p><small>PREPARE SEPARATE FORM FOR EACH CHILD IF MULTIPLE BIRTH.</small></p> <p><small>ATTENDANT MUST SIGN. POWER OF SIGNATURE CANNOT BE DELEGATED.</small></p> <p><small>ATTENDANT MUST FILE THIS CERTIFICATE WITH THE LOCAL REGISTRAR WITHIN 10 DAYS AFTER BIRTH.</small></p> <p><small>GIVE MOTHER'S MAILING ADDRESS. A FREE PHOTOGRAPHIC COPY OF THIS CERTIFICATE WILL BE SENT TO HER.</small></p> <p><small>ITEMS 21-23 ARE FOR MEDICAL AND HEALTH USE ONLY AND WILL NOT APPEAR ON COPIES.</small></p> <p><small>ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.</small></p> <p><small>FORM 100</small></p>		<p>CERTIFICATE OF LIVE BIRTH DEPARTMENT OF PUBLIC HEALTH - STATE OF TENNESSEE - DIVISION OF VITAL STATISTICS COOPERATING WITH NATIONAL OFFICE OF VITAL STATISTICS</p>			
		BIRTH NO. 141-			
1. NAME OF CHILD					
FIRST		MIDDLE		LAST	
2. SEX	3a. THIS BIRTH		3b. IF TWIN OR TRIPLET, THIS CHILD BORN		
	SINGLE <input type="checkbox"/> TWIN <input type="checkbox"/> TRIPLET <input type="checkbox"/>		1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/>		
5. PLACE OF BIRTH		6. USUAL RESIDENCE OF MOTHER (WHERE DOES MOTHER LIVE?)			
a. COUNTY		b. CIVIL DISTRICT		c. CIVIL DISTRICT	
c. CITY (IF OUTSIDE CITY LIMITS WRITE RURAL) OR TOWN		d. CITY (IF OUTSIDE CITY LIMITS, WRITE RURAL) OR TOWN		e. STREET (IF RURAL, GIVE LOCATION) ADDRESS	
FATHER OF CHILD					
7. FULL NAME		8. COLOR OR RACE			
9. AGE (AT TIME OF THIS BIRTH) YEARS		10. BIRTHPLACE (State or Foreign Country)		11a. USUAL OCCUPATION	
				11b. KIND OF BUSINESS OR INDUSTRY	
MOTHER OF CHILD					
12. FULL MAIDEN NAME		13. COLOR OR RACE			
14. AGE (AT TIME OF THIS BIRTH) YEARS		15. BIRTHPLACE (State or Foreign Country)		16a. USUAL OCCUPATION	
				16b. KIND OF BUSINESS OR INDUSTRY	
17. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (DO NOT INCLUDE THIS CHILD)		a. HOW MANY OTHER CHILDREN ARE NOW LIVING?		b. HOW MANY OTHER CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD?	
18. MOTHER'S MAILING ADDRESS		c. HOW MANY CHILDREN WERE STILLBORN (BORN DEAD AFTER 20 WEEKS OF PREGNANCY)?			
19. SIGNATURE		a. I HEREBY CERTIFY THAT THIS CHILD WAS BORN ALIVE ON DATE STATED ABOVE			
NAME		b. ATTENDANT AT BIRTH			
c. ADDRESS		M.D. <input type="checkbox"/> MID. <input type="checkbox"/> WIFE <input type="checkbox"/> OTHER (SPECIFY)			
		d. DATE SIGNED			
20a. REGISTRATION DISTRICT NO.		20b. DATE RECEIVED BY LOCAL REGISTRAR		20c. REGISTRAR'S SIGNATURE	
FOR MEDICAL AND HEALTH USE ONLY					
21a. LENGTH OF PREGNANCY WEEKS		21b. WEIGHT AT BIRTH LBS. OZS.		22. LEGITIMATE YES <input type="checkbox"/> NO <input type="checkbox"/>	
BIRTH INJURY AND/OR CONGENITAL MALFORMATIONS (CONTINUED)		23. BIRTH INJURY AND/OR CONGENITAL MALFORMATIONS			

PURPOSE: To record data necessary for report and registration of a live birth within twelve months after date of birth.

EXPLANATION AND DEFINITIONS: *Birth Number* will be completed in the Division of Vital Statistics of the Tennessee Department of Public Health. The number is divided into three parts:

141 - 49 - 000001
Tennessee Year Assigned Number

All other items are to be completed except data relative to father on certificate of illegitimate child.

USED BY: Physicians, midwives, registrars, health department personnel, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: The attendant (physician, midwife, or other person) is required to file a completed birth certificate with the local or deputy registrar within ten (10) days following the birth. Certificate must be signed by actual attendant. The clerk or registrar checks certificates and prepared summary cards (Form 101). No addition of missing information is to be made on the face of the certificate by the clerk or registrar. Additional information obtained from a reliable source intended to complete items may be entered on the back of the certificate in ink over the signature (not initials) of the person giving the information (registrar, health officer, etc.). These notations are not to extend beyond the binding margin of the certificate. Without the signature, the information cannot be used. Altered certificates will not be accepted.

If a new, corrected certificate is obtained and substituted, the registrar's name and new filing date must be added to the substitute. All certificates are due in the office of the Division of Vital Statistics on or before the *tenth* of the month.

COMMENT: The data relative to the father must be omitted on the certificate of an illegitimate child. The child is given the legal surname of the mother. If the mother is unmarried, her maiden name is given the child. If the mother is divorced or widowed, her legal name is given the child and both her maiden name and legal name shown in the space for name of mother. For example, Mrs. Joe Doe has an illegitimate child; the child is named Doe, and the maiden name of the mother is shown as Mary Smith (Doe).

Additions may be made to summary cards for the files in a local health department. These additions are to be in red ink to indicate that the card does not agree with the certificate as submitted.

The clerk never marks a certificate "copy" or "duplicate." If a certificate is thought to be a duplicate, a slip of paper on which the word "duplicate" is written is attached to the certificate. Staples are not to be used.

On the certificate of a birth attended by a midwife who cannot write, the midwife's name is written on the proper line as attendant, the midwife makes her "X" mark, and someone who has witnessed her make the mark signs the certificate as "Witness."

For details see *Vital Statistics Registration Manual*.

12-14-48

SUMMARY CARD - LIVE BIRTH - FORM 101
SIZE 4" x 6"

NAME _____		BIRTH NUMBER _____	
LAST	FIRST	MIDDLE	
COLOR _____	SEX _____	SINGLE OR PLURAL _____	DATE OF BIRTH _____
PLACE OF BIRTH: COUNTY _____	CIVIL DIST. _____	CITY OR TOWN _____	HOSPITAL _____
USUAL RESIDENCE: STATE _____		COUNTY _____	CIVIL DIST. _____
CITY OR TOWN _____		STREET ADDRESS _____	
FATHER _____		OCCUPATION AND INDUSTRY _____	
MOTHER _____		OCCUPATION AND INDUSTRY _____	
CHILDREN PREVIOUSLY BORN TO THIS MOTHER _____	A. HOW MANY OTHER CHILDREN ARE NOW LIVING? _____	B. HOW MANY OTHER CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD? _____	C. HOW MANY CHILDREN WERE STILLBORN? _____
MOTHER'S MAILING ADDRESS _____			
LENGTH OF PREGNANCY _____ WKS.; WEIGHT AT BIRTH _____ LBS. _____ OZS. LEGITIMATE: YES <input type="checkbox"/> NO <input type="checkbox"/>			
BIRTH INJURY AND/OR CONGENITAL MALFORMATIONS _____			
DATE RECORDED _____		ATTENDANT _____	
<input type="checkbox"/> M.D. <input type="checkbox"/> MIDWIFE <input type="checkbox"/> OTHER			

SUMMARY CARD - LIVE BIRTH TENNESSEE DEPT. PUBLIC HEALTH - 101

PURPOSE: To provide an office record of a live birth which serves for reference and for study purposes.

EXPLANATION AND DEFINITIONS:

Birth Number: This will be assigned in the Division of Vital Statistics of the Tennessee Department of Public Health.

Date Recorded: Enter the date that the acceptable certificate is received in the county health department.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: The clerk makes one of these cards for each acceptable birth certificate, or photostatic copy of certificate, received. These cards, filed alphabetically in two files--(1) current year, and (2) all other years--are used as an index and for special tabulations of births by month or year. It is against these files that infant deaths and names of all infants under health department supervision are checked for completeness of birth reporting. (When a photostatic copy of a certificate is returned with a notation that the certificate was not accepted for filing, and the period for filing a current certificate has passed, the clerk makes similar notation on summary card in files.)

Cards for infants born in the area to mothers residing outside the area served by the health department are marked "non-resident." Cards made from photostatic copies of certificates for infants born outside the area to mothers residing in the area are marked to distinguish them from cards for certificates originally routed through the local office.

COMMENT: This card assembles in summary form all data from the birth certificate which a local health department needs for monthly or annual tabulations, and for planning local program.

UNREPORTED BIRTH - FORM 102
SIZE 3" x 5"

Name _____	Date of Birth _____
Place of Birth _____	Color _____ Sex _____
Father _____	
Mother (Maiden Name) _____	
Address _____	
Attendant at Birth _____	
<small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 102</small>	

PURPOSE: To furnish names of infants under one year residing in the county for whom birth certificate has not been received.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Health Department Personnel.

OFFICE MECHANICS AND FILING: One of these cards is made by the clerk and filed *by month of birth* under the following circumstances:

1. When a health or maternity record shows an *infant's* name for the first time, (and his birth has occurred since the department has been receiving records), the name is checked against the birth certificate index file. If the birth is not recorded and the residence is in the jurisdiction of the health department, a card is made. Notation is made in pencil on the record that birth is not reported. The health officer or nurse calls the mother's attention to the lack of registration and urges her to have her attendant make report. If certificate is not received by the time the infant is one month of age, a card is mailed to the parents. This card should point out that certificate is more valuable if it is filed soon after birth. If after diligent effort, the registrar does not secure the certificate he reports the violation to the State Registrar on form 105. This form (105) is signed by local registrar.

2. When an institution report shows a birth has occurred and no original certificate has been submitted, a card is made.

3. When information from other sources (welfare agencies, newspaper articles, etc.) shows a birth has occurred and no original certificate has been submitted, a card is made.

These cards are kept in Unreported Birth File until either the certificate, or a summary card is received from the Division of Vital Statistics, or, if born in another county, until the photostatic copy of certificate is received. This file should be set up to cover a period of twelve months. Each month the cards for infants who reached their first birthday during the preceding month should be moved back to an alphabetical arrangement behind the chronological file. At that time the guide card for that month should be moved back to be used for the next calendar year.

COMMENT: For details see Vital Statistics Registration Manual.

Page 103 missing

INSTITUTIONAL REPORT OF BIRTHS - FORM 104
SIZE 11" x 8½"

[illegible]

PURPOSE: To furnish the local registrar and Division of Vital Statistics with a means of discovering unreported births.

EXPLANATION AND DEFINITIONS: The local registrar is responsible for distributing and collecting these forms. Each superintendent, manager or other person in charge of a hospital, almshouse, lying-in or other institution, public or private, including penal institutions, to which persons resort for treatment of disease, injury or childbirth, or are committed by process of law, is required to complete this form and submit it to the local registrar on the first day of each month.

The local registrar must check the list against the birth certificates for the unreported births, and send the lists to the Division of Vital Statistics in the monthly report.

USED BY: Institutions, local registrar, health department personnel, Division of Vital Statistics.

COMMENT: For detailed instructions see Vital Statistics Registration Manual.

REPORT OF FAILURE TO FILE BIRTH CERTIFICATE - FORM 105
 SIZE 11" x 8½"

STATE OF TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF VITAL STATISTICS	
REPORT OF FAILURE TO FILE BIRTH CERTIFICATE	
FULL NAME OF CHILD: _____	
DATE OF BIRTH: _____	AT _____ M. SEX: _____
PLACE OF BIRTH: COUNTY _____	CIVIL DISTRICT _____
CITY OR TOWN _____	
ADDRESS _____	
FULL NAME OF THE FATHER: _____	COLOR OR RACE _____
MOTHER'S MAIDEN NAME: _____	COLOR OR RACE _____
MOTHER'S MAILING ADDRESS: _____	
NAME AND ADDRESS OF ATTENDANT: _____	
HOW LONG HAD THE ATTENDANT BEEN PRESENT WHEN THE CHILD WAS BORN? APPROXIMATELY _____ HOURS?	
WHAT DOCTOR CARED FOR THE MOTHER PRIOR TO THE BIRTH? _____	
DID THE ATTENDANT ASK THE QUESTIONS NECESSARY FOR PREPARING A BIRTH CERTIFICATE? _____	
NAMES AND ADDRESSES OF OTHER PERSONS PRESENT AT THE TIME OF THIS BIRTH: _____	

STATE DATES AND EFFORTS MADE TO SECURE THIS CERTIFICATE _____	
REMARKS: _____	

I hereby certify that the foregoing facts are true and correct to the best of my knowledge.	
SIGNED _____	LOCAL REGISTRAR
DATE _____	
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 105	

PURPOSE: To provide formal notification to Division of Vital Statistics by local registrars that a violation of the vital statistics law has occurred in the jurisdiction from which the report is made.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Local registrars, Division of Vital Statistics.

OFFICE USE AND FILING MECHANICS: If a birth certificate has not been filed after reasonable attempts have been made by the registrar to obtain it, complete data should be given on this form. Complete and accurate details are necessary for proper checking in the Division of Vital Statistics, to see that the certificate in question is not already on file.

COMMENT: This requirement is not optional with registrars, but is mandatory.

For details see Vital Statistics Registration Manual.

REQUEST FOR CERTIFIED COPY OF CERTIFICATE OF BIRTH - FORM 106
 SIZE 5½" x 8½"

FRCNT

REQUEST FOR CERTIFIED COPY OF CERTIFICATE OF BIRTH			
TO: DIVISION OF VITAL STATISTICS TENNESSEE DEPARTMENT OF PUBLIC HEALTH 420 BIRTH AVENUE, NORTH NASHVILLE 9, TENNESSEE		DATE _____	
PLEASE SEARCH YOUR RECORDS FOR THE BIRTH CERTIFICATE DESCRIBED BELOW.			
FULL NAME AT BIRTH _____			
DATE OF BIRTH _____		SEX _____ COLOR _____	
MONTH _____ DAY _____ YEAR _____			
PLACE OF BIRTH _____			
CITY _____		COUNTY _____ STATE _____	
FULL NAME OF FATHER _____			
MAIDEN NAME OF MOTHER _____			
PURPOSE FOR WHICH CERTIFICATE IS TO BE USED _____			
SIGNED _____			
ADDRESS _____			
FEE FOR MAKING SEARCH		\$	1 00
FIRST CERTIFIED COPY (NO EXTRA CHARGE IF CERTIFICATE IS ON FILE)			00
ADDITIONAL CERTIFIED COPIES _____ @ \$1.00 EACH			
ENCLOSED FIND MY REMITTANCE FOR		\$	

PLEASE NOTE INSTRUCTIONS ON BACK

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 106

INSTRUCTIONS

Give complete information as listed. Use typewriter if possible, or print plainly. If exact date of birth is unknown, give approximate age or year of birth.

If no certificate is on file a fee of one dollar for searching the records as provided in Sec. 15, Chapter 23, Public Acts of 1941, as amended, will be charged. There will be an additional charge of one dollar for each certified copy of a delayed certificate subsequently filed. Remittance should be sent by money order. Personal checks will not be accepted. **Do not send cash.**

Certified copies of birth records are not issued without fee.

PURPOSE: To provide a form for requesting a certified copy of a birth certificate.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Local health department personnel, general public, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: This form is kept in the local health department office for the convenience of the general public. In furnishing this form, the worker should stress the importance of filling in each item. No letter need accompany this form.

Certified copy requests must be accompanied by a fee of one dollar (\$1.00) for each copy requested. Personal checks are not accepted.

REQUEST FOR BIRTH REGISTRATION - IDENTIFICATION CARD - FORM 107
SIZE 11" x 8½"

BIRTH REGISTRATION—IDENTIFICATION CARD TENNESSEE DEPARTMENT OF PUBLIC HEALTH NASHVILLE									
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p align="center">BIRTH REGISTRATION CARD TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF NASHVILLE VITAL STATISTICS TENNESSEE</p> <p>NAME _____ DATE _____</p> <p>BIRTH PLACE _____ STATE OF TENNESSEE _____</p> <p>RACE _____ SEX _____</p> <p>RECORD FILED _____ CARD ISSUED _____</p> <p><small>THIS CERTIFICATE THAT THE ABOVE IS A TRUE COPY OF FACTS RECORDED ON BIRTH RECORD OF THE INDIVIDUAL NAMED HEREON, SAID RECORD BEING ON FILE IN THIS OFFICE.</small></p> <p align="right"><small>R. H. HUTCHESON, M.D. COMMISSIONER DEPARTMENT OF PUBLIC HEALTH</small></p> <p><small>BY: STATE REGISTER OF VITAL STATISTICS RECEIVED ONLY IF RETURNED TO STATE OF TENNESSEE</small></p> </div> <p align="center">Front</p>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p align="center"><small>THIS SIDE OF CARD COMPLETED AT THE OPTION OF APPLICANT</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">HEIGHT</td> <td style="width: 25%;">WEIGHT</td> <td style="width: 25%;">HAIR</td> <td style="width: 25%;">EYES</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> <p align="center">SOCIAL SECURITY NUMBER</p> <p> </p> <p align="center">HOME ADDRESS</p> <p> </p> <p align="center">SIGNATURE</p> <p> </p> </div> <p align="center">Back</p>	HEIGHT	WEIGHT	HAIR	EYES				
HEIGHT	WEIGHT	HAIR	EYES						
<p>ILLUSTRATED ABOVE, ACTUAL SIZE, IS THE BIRTH REGISTRATION AND IDENTIFICATION CARD ISSUED BY THE DEPARTMENT OF PUBLIC HEALTH. THIS CARD IS SEALED IN HEAVY WATERPROOF PLASTIC AND MAY BE CARRIED AT ALL TIMES IN YOUR PURSE OR BILLFOLD.</p> <p>THIS CARD IS ISSUED ONLY TO PERSONS BORN IN TENNESSEE, WHOSE BIRTHS ARE REGISTERED, OR WILL BE REGISTERED BEFORE ISSUING A CARD. ENCLOSE WITH YOUR APPLICATION AN UNMOUNTED PICTURE OF YOURSELF WHICH MAY BE TRIMMED TO SIZE SHOWN ABOVE, (1 1/4 INCHES ACROSS SHOULDERS). GIVE ACCURATE INFORMATION. ENCLOSE FEE OF \$1.00. PERSONAL CHECKS NOT ACCEPTED. USE FORM 141 (GREEN) IF YOU DESIRE A PHOTOSTAT CERTIFIED COPY. PLEASE PRINT OR USE TYPEWRITER IN FILLING OUT APPLICATION. SIGNATURE MUST BE IN INK.</p> <p>TO: DIVISION OF VITAL STATISTICS TENNESSEE DEPARTMENT OF PUBLIC HEALTH 420 SIXTH AVENUE, NORTH NASHVILLE 3, TENNESSEE</p> <p align="right">DATE _____</p> <p>PLEASE SEND ME A BIRTH CARD BASED ON MY BIRTH CERTIFICATE AND THE FOLLOWING INFORMATION. ENCLOSED ARE MY PICTURE AND MONEY ORDER FOR \$1.00.</p> <p>FULL NAME AT BIRTH _____</p> <p>DATE OF BIRTH _____ MONTH _____ DAY _____ YEAR _____ COLOR _____ SEX _____</p> <p>PLACE OF BIRTH _____ CITY _____ COUNTY _____ TENNESSEE _____</p> <p>FULL NAME OF FATHER _____</p> <p>MAIDEN NAME OF MOTHER _____</p> <p>HEIGHT _____ WEIGHT _____ COLOR OF HAIR _____ COLOR OF EYES _____</p> <p>SOCIAL SECURITY NUMBER _____</p> <p>HOME ADDRESS _____ NUMBER & STREET _____ CITY OR TOWN _____ STATE _____</p> <p>WRITE IN INK YOUR USUAL SIGNATURE IN THE SPACE BELOW</p> <div style="border: 1px solid black; width: 150px; height: 30px; margin-bottom: 5px;"></div> <p align="center">SIGNATURE BY MAIL</p> <p>SIGNED _____</p> <p>MAIL CARD TO _____ NUMBER & STREET _____ CITY _____ STATE _____</p> <p align="right"><small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 107</small></p>									

PURPOSE: To provide a form for requesting a birth registration - identification card.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Local health department personnel, general public, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: This form is kept in the local health department office for the convenience of the general public. In furnishing this form, the worker should stress the importance of filling in each item. No letter need accompany this form.

Birth registration - identification card requests must be accompanied by a fee of one dollar (\$1.00) for each card requested. Personal checks are not accepted.

Page 108 missing

BIRTH REPORT OF FOUNDLING - FORM 109
SIZE 6½" x 8½"

BIRTH REPORT OF FOUNDLING	
<p>AUTHORITY TO FILE THIS RECORD IS PROVIDED BY SECTION 31, CHAPTER 23, PUBLIC ACTS OF 1941.</p> <p>DATA REQUIRED ARE TO BE SUPPLIED BY THE PERSON FINDING THIS CHILD. OVER HIS SIGNATURE.</p> <p>THIS REPORT SHALL BE SUBJECT TO THE SAME CONDITIONS GOVERNING A CERTIFICATE OF BIRTH.</p> <p>WRITE PLAINLY. USE INK.</p> <p>ALL ITEMS TO BE COMPLETE AND ACCURATE.</p> <p style="text-align: center; font-size: small;">FORM 109</p>	<div style="text-align: right; font-size: x-small;"> REG. NO. _____ REG. DIST. NO. _____ </div> <div style="margin-top: 10px;"> 1. NAME ASSIGNED _____ </div> <div style="margin-top: 10px;"> 2. PLACE FOUND: A. COUNTY _____ CIVIL DISTRICT _____ B. CITY OR TOWN _____ (IF OUTSIDE CITY OR TOWN LIMITS, WRITE RURAL) </div> <div style="margin-top: 10px;"> 3. DATE FOUND _____ APPROX. DATE OF BIRTH _____ </div> <div style="margin-top: 10px;"> 4. SEX _____ 5. COLOR OR RACE _____ </div> <div style="margin-top: 10px;"> 6. PERSON OR INSTITUTION WITH WHOM THE CHILD HAS BEEN PLACED FOR CARE: A. NAME _____ B. ADDRESS _____ </div> <div style="margin-top: 10px;"> 7. NAME ASSIGNED BY: _____ </div> <div style="margin-top: 10px;"> 8. OTHER IDENTIFYING DATA: _____ _____ _____ </div> <div style="margin-top: 20px; text-align: center;"> PERSON FINDING THIS CHILD _____ (SIGNATURE) </div> <div style="margin-top: 10px;"> DATE RECEIVED BY LOCAL REGISTRAR _____ 194 _____ ADDRESS _____ </div> <div style="margin-top: 10px;"> REGISTRAR'S SIGNATURE _____ DATE SIGNED _____ </div>

PURPOSE: To record data necessary for report and registration of a living child of unknown parentage.

EXPLANATION AND DEFINITIONS: For detailed instructions see Vital Statistics Registration Manual.

USED BY: Individual finding the child, registrars, health department personnel, Division of Vital Statistics.

OFFICE MECHANICS AND HANDLING: See instructions given for birth certificate, Form 100.

COMMENT: The place where a foundling child is found shall be known as the place of birth, and the approximate date of birth shall be recorded as the date of birth.

The person, superintendent or manager of the institution with whom a foundling child is placed for care shall give the child a name and report that name to the local registrar of the district in which institution is located within ten (10) days after the child has been received.

If the foundling child is later identified and a regular birth certificate is found or obtained, the foundling certificate is to be destroyed by the State Registrar upon satisfactory proof of identity.

DELAYED CERTIFICATE OF BIRTH - FORM 110 SIZE 7 1/4" x 8 3/4"

FRONT

NOTE CAREFULLY
THIS IS A PERMANENT LEGAL RECORD
USE TYPEWRITER OR WRITE PLAINLY WITH UNFADING INK—CHECK ALL
STATEMENTS. ALTERATIONS WILL BE MADE ONLY ON ORDER OF
A COURT OF RECORD IN TENNESSEE

DELAYED CERTIFICATE OF BIRTH

STATE OF TENNESSEE
 DEPT. OF PUBLIC HEALTH
 DIV. OF VITAL STATISTICS

FILE NUMBER

D-

NAME AT BIRTH _____ DATE OF BIRTH _____

BIRTHPLACE _____ COLOR OR RACE _____ SEX _____

FATHER: FULL NAME _____ BIRTHPLACE _____ STATE OR COUNTRY _____

MOTHER: MAIDEN NAME _____ BIRTHPLACE _____ STATE OR COUNTRY _____

I HEREBY CERTIFY, ON OATH, THAT THE ABOVE STATEMENTS ARE TRUE. (TO BE SIGNED BY PARENT OR LEGAL GUARDIAN IF REGISTRANT IS UNDER 12 YEARS OF AGE.)

SIGNATURE OF REGISTRANT _____ PRESENT ADDRESS _____

SUBSCRIBED AND SWORN TO BEFORE ME ON _____ 19____ NOTARY PUBLIC _____

REGISTRANT—DO NOT WRITE BELOW THIS LINE

ABSTRACT OF SUPPORTING EVIDENCE	
NAME AND KIND OF DOCUMENT (INCLUDING BY WHOM ISSUED AND SIGNED, AND DATE OF ISSUE)	DATE ORIGINAL DOCUMENT WAS MADE
1	
2	
3	
4	
5	
6	

INFORMATION CONCERNING REGISTRANT AS STATED IN DOCUMENT OF CORRESPONDING NUMBER ABOVE			
BIRTH DATE OR AGE	BIRTHPLACE	NAME OF FATHER	FULL NAME OF MOTHER
1			
2			
3			
4			
5			
6			

I HEREBY CERTIFY THAT I HAVE EXAMINED THE _____ DOCUMENTS ABSTRACTED ABOVE, FIND THEM VALID, AND THAT THE INFORMATION CONTAINED THEREIN IS AS NOTED ABOVE, AND RECOMMEND THAT THIS DELAYED CERTIFICATE OF BIRTH BE ACCEPTED FOR FILING BY THE DIVISION OF VITAL STATISTICS, TENNESSEE DEPARTMENT OF PUBLIC HEALTH.

SIGNED _____ ADDRESS _____ DATE _____ 19____
(CIRCUIT COURT JUDGE, DISTRICT ATTORNEY GENERAL, CLERK AND MASTER)

THIS DELAYED CERTIFICATE OF BIRTH IS NOT VALID UNTIL APPROVED BY THE TENNESSEE STATE REGISTRAR OF VITAL STATISTICS OR HIS AUTHORIZED AGENT.

APPROVED: _____ DATE: _____ BY: _____

BACK

STATE OF _____ } SS

COUNTY OF _____

I HEREBY CERTIFY, ON OATH, THAT I AM AT PRESENT _____ YEARS OF AGE; THAT I AM RELATED TO THE PERSON REPRESENTED BY THIS CERTIFICATE AS _____, AND THAT I HAD ACTUAL KNOWLEDGE OF THE FACTS AS STATED IN THIS CERTIFICATE AT THE TIME THE BIRTH OCCURRED, AND KNOW THEM TO BE TRUE BECAUSE _____

 SIGNATURE: _____ PRESENT ADDRESS: _____

I HEREBY CERTIFY THAT THIS AFFIANT PERSONALLY APPEARED BEFORE ME, THAT I READ THE ABOVE STATEMENTS TO _____ AND THAT _____ MADE OATH THAT SAID STATEMENTS ARE TRUE TO THE BEST OF _____ KNOWLEDGE AND BELIEF.

THIS THE _____ DAY OF _____ 19____

SEAL _____ NOTARY PUBLIC _____

MY COMMISSION EXPIRES _____

STATE OF _____ } SS

COUNTY OF _____

I HEREBY CERTIFY, ON OATH, THAT I AM AT PRESENT _____ YEARS OF AGE, THAT I AM NOT RELATED TO THE PERSON REPRESENTED BY THIS CERTIFICATE, AND THAT I HAD ACTUAL KNOWLEDGE OF THE FACTS AS STATED IN THIS CERTIFICATE AT THE TIME THE BIRTH OCCURRED, AND KNOW THEM TO BE TRUE BECAUSE _____

 SIGNATURE: _____ PRESENT ADDRESS: _____

I HEREBY CERTIFY THAT THIS AFFIANT PERSONALLY APPEARED BEFORE ME, THAT I READ THE ABOVE STATEMENTS TO _____ AND THAT _____ MADE OATH THAT SAID STATEMENTS ARE TRUE TO THE BEST OF _____ KNOWLEDGE AND BELIEF.

THIS THE _____ DAY OF _____ 19____

SEAL _____ NOTARY PUBLIC _____

MY COMMISSION EXPIRES _____

DELAYED CERTIFICATE OF BIRTH - FORM 110

PURPOSE: To provide legal registration of an unregistered birth occurring in Tennessee twelve months or more prior to date of filing in the Division of Vital Statistics, Tennessee Department of Public Health.

EXPLANATION AND DEFINITION: The births of individuals twelve (12) months or more of age may be registered only on the form, Delayed Certificate of Birth.

OFFICE MECHANICS AND FILING: Delayed certificates should be received regardless of place of birth of child in Tennessee and forwarded to Division of Vital Statistics. These certificates must not be sent in franked envelopes.

COMMENT: See Delayed Birth Registration, Form 111 and Vital Statistics Registration Manual.

11-3-47

DELAYED REGISTRATION OF BIRTHS - INSTRUCTIONS - FORM 111
SIZE 11" x 8½"

FRONT

STATE OF TENNESSEE
 DEPARTMENT OF PUBLIC HEALTH
 NASHVILLE

DELAYED BIRTH REGISTRATION

A. GENERAL INFORMATION.

1. Only persons born in the State of Tennessee may register their births with the Tennessee Department of Public Health.
2. Delayed birth registration is not permissible if the birth has been previously recorded in Tennessee. Birth records are available in the Division of Vital Statistics from 1908 to the present time. These records should be searched before effort is made to complete the delayed form. There is a fee of one dollar (\$1.00) required for the search of the records.
3. An unregistered birth of an individual twelve (12) months or more of age must be registered on the delayed certificate of birth form.
4. All information must be written legibly in ink or on the typewriter. The certificate cannot be accepted if it contains alterations or erasures. All signatures must be in ink.
5. No certificate will be accepted which shows the married name of a female applicant in item "Name at Birth".
6. Delayed birth registration is permissible for a deceased person if the fact of death is satisfactorily established.
7. Neither an individual applicant nor a Notary Public (or Justice of the Peace) is permitted to complete the section "Abstract of Supporting Evidence".

B. INSTRUCTIONS FOR COMPLETION OF THE DELAYED CERTIFICATE OF BIRTH.

1. The preparation of the items follows:

Name at Birth--Follow order as indicated on the certificate: *First-Middle-Last.*

Date of Birth--Enter the month, day and year. Write out or abbreviate month--do not use a number.

Birthplace--County--Enter in full. City or Town--Enter city or town regardless of size. If birth occurred outside city or town, enter "rural" after the name of the city or town.

Color or Race--Enter as White, Black or Negro, Indian, Chinese, or whatever the race may be.

Sex--Enter male or female.

Father: Full Name--Enter in full the first, middle and surname. If the child is NOT legitimate, all information concerning the father must be omitted.

Birthplace--Enter the State (U.S.A.) or foreign country, as the case may be.

Mother: Maiden Name--Enter first given name, middle name and NAME BEFORE MARRIAGE.

Birthplace--Enter the State (U.S.A.) or foreign country, as the case may be.

Signature of Registrant--The signature must be entered by the registrant in the presence of a Notary Public unless one of the following circumstances exists:

a. If the registrant is under twelve (12) years of age, the parent or legal guardian should sign and indicate his relationship.

b. If fact of death is established, no signature is required.

NOTE: A married woman should sign her legal surname as of the date the affidavit is made and NOT as of the time of birth.

2. Minimum Requirements for Establishing a Delayed Certificate of Birth Are:

- a. Four (4) facts of birth (date of birth or age, birthplace, name of father, and name of mother) must be proved one (1) time by documents or records.

An original document not less than five (5) years old is required (or a properly certified copy thereof) if registrant is twelve (12) years old or more. For registrant under twelve (12), the oldest available record should be used.

- b. An affidavit or affidavits on the reverse of the form may be secured to prove the four (4) facts of birth.

(1) One (1) affidavit is required, in addition to the documentary evidence, if the attendant or parent makes the affidavit.

(2) Two (2) affidavits are required in addition to the documentary evidence, when neither attendant nor parent signs the record.

A person who makes an affidavit to establish the facts of birth on the delayed record must be at least ten (10) years older than the registrant and have had actual knowledge of the birth at the time the birth occurred.

(3) Only one (1) relative by blood or marriage is permitted to make an affidavit. One (1) relative and one (1) non-relative or two (2) non-relatives should sign the delayed record.

- c. If impossible to secure the affidavits, the four (4) facts of birth must be supported by at least TWO (2) pieces of documentary evidence.

BACK

- d. If *insufficient* documentary evidence and affidavits are available, the facts of birth may be established in a Court of Record in the State of Tennessee. All items or facts of birth on the delayed certificate must be included in the court order and a certified copy of the court order submitted for permanent filing with the delayed certificate. *All information on the Delayed Certificate and Court Order must be consistent.*
3. List of Officials Permitted by Regulations to Examine and Certify to the Authenticity of Documents Submitted for Proof of the Facts of Birth follows:
- | | |
|------------------------------|--|
| a. Circuit Court Judge | e. County Judge |
| b. Circuit Court Clerk | f. County Court Clerk |
| c. District Attorney General | g. An official in another State who corresponds in rank to one of the Tennessee officials named above. |
| d. Clerk and Master | h. Tennessee State Registrar of Vital Statistics |

4. Instructions for Officials for the Completion of the Abstract of Supporting Evidence follows:

Neither an individual applicant nor a Notary Public (or Justice of the Peace) is permitted to complete the Abstract of Supporting Evidence.

Name and Kind of Document—*The documents or records and affidavits that prove the facts of birth must be entered in this space. Each entry should be made on a separate line.*

The date on which the *original document* or affidavit was made should be placed on the proper line in the column on the right. Do not use in this space the date the certified copy of the original was made. The date given will determine whether the evidence other than affidavits is five (5) or more years old.

Information Concerning Registrant as Stated in Document of Corresponding Number Above—*Enter ONLY the information actually contained in the documents.*

If a document shows the registrant twenty three (23) years old next birthday, the entry should be made as follows: "23 years next birthday." If a document shows the registrant was born in Tennessee, the entry should show *Tennessee*, and not Davidson County, Tennessee.

Affidavits made on the reverse of the form prove the facts of birth as stated on the face of the delayed certificate.

Certification—*The number of documents examined, including affidavits on reverse of certificate, must be entered by the official in addition to his signature, address and the date of his certification.*

Approved—*This space is provided for the Division of Vital Statistics and should be left blank.*

C. SUGGESTIONS FOR SECURING SATISFACTORY DOCUMENTARY EVIDENCE TO ESTABLISH FACTS OF BIRTH.

Documents That Usually Prove Age, Place of Birth, and Names of Parents

- | | |
|---|---|
| a. Federal Census Record (if made when registrant was in the home of his parents) | d. Social Security Record (information given on original application) |
| b. Physician's Office Record | e. Marriage Record (few states excellent - Tennessee only good for age until July 1945) |
| c. Health Department Record | f. Report of Induction of Selective Service Man |

Documents That Usually Prove Age and Place of Birth

- | | | |
|---|-------------------------------|--------------------------|
| a. Birth Certificate of Son or Daughter | d. Military Record | g. Federal Census Record |
| b. Insurance Policy | e. School Record | |
| c. Hospital Record | f. Voting Registration Record | |

Documents That Usually Prove Date of Birth or Age, and Names of Parents

- | | |
|------------------|---|
| a. Bible Record | c. Genealogical Record |
| b. School Record | d. Insurance Policy (if parent (or parents) named as beneficiary) |

Documents That Usually Prove Names of Parents

- | | |
|------------------|---|
| a. Death Notice | d. Insurance Policy (if registrant beneficiary) |
| b. Property Deed | e. Marriage Record of Parents |
| c. Will | f. Birth or Death Record of Sister or Brother |

D. INSTRUCTIONS FOR SUBMITTING DELAYED BIRTH CERTIFICATE FOR FILING.

Send completed delayed birth certificate (*or delayed certificate and documentary evidence*) and legal fee of one dollar (\$1.00) (*if certified copy is desired*) directly to:

Division of Vital Statistics
Tennessee Department of Public Health
420 Sixth Avenue, North
Nashville, Tennessee

Pages 112-113 missing

BIRTH REPORT CARD TO HEALTH DEPARTMENT
U.S.P.H.S. FORM 614(VS) - (FORM 114)
SIZE 3 1/2" x 5 1/2"

FRONT

**FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE
NATIONAL OFFICE OF VITAL STATISTICS
WASHINGTON 25, D. C.**

OFFICIAL BUSINESS
420 SIXTH AVENUE, NORTH
NASHVILLE 3, TENNESSEE

PENALTY FOR PRIVATE USE TO AVOID
PAYMENT OF POSTAGE, \$300
(GPO)

SPECIAL AGENT, U. S. PUBLIC HEALTH SERVICE

____COUNTY HEALTH DEPARTMENT

_____, TENNESSEE

BACK

Form approved—Budget Bureau No. 68-R308.

Just after your baby is born fill in this card and mail it. No postage is required.

This card is not a birth certificate but it will make sure that your baby's birth will be registered.

Dr. R. H. HUTCHESON,
Special Agent, Public Health Service.

GPO 16-54349-1

My baby was born on _____
(Month) (Day) (Year)

in _____
(County) (State)

Father's full name _____ Color _____

Name of doctor or midwife _____

My name _____

My address

PHS-614 (VS)
(old number VS 327(48))
1-48

BIRTH REPORT CARD TO HEALTH DEPARTMENT
U.S.P.H.S. FORM 614(VS) - (FORM 114)

PURPOSE: To inform the local health department of the arrival of a baby and to insure that a Certificate of Live Birth, Form 100, is filed.

EXPLANATION AND DEFINITIONS: The clerk in the health department places the address of the health department on the front of the card. The nurse distributes these cards to her antepartum cases to mail to the health department on arrival of the baby. The use of this card could be explained in prenatal classes so that any mother in the county desiring to inform the health department of birth could do so.

When returned, this card is used by the nurse. The clerk prepares an Unreported Birth Card, Form 102, if birth certificate has not been filed. If unfiled, she assists in getting the certificate filed as soon as possible.

USED BY: Mother, nurse and clerk.

COMMENT: No postage is needed for returning this card to the local health department. This card is an aid to birth registration.

GREETINGS TO PARENTS - FORM 115
 SIZE 3½"X 5½"

FIRST PAGE

Greetings To Parents

From

The Tennessee Department of Public Health

NASHVILLE 3, TENNESSEE

The enclosed photograph of your child's birth certificate is evidence that your child's birth has been registered and is permanently filed with this department.

You should keep this photograph of the certificate for your child's future use.

SECOND PAGE

PREVENTION OF CHILDHOOD DISEASES

WHOOPING COUGH—This disease causes deaths of young children. Many of these deaths are of babies less than one year of age. Your child should be protected from the disease by having him given whooping cough vaccine after three months of age.

DIPHTHERIA—When your child is nine months of age, he should be protected against diphtheria by having him given two doses of diphtheria toxoid.

THIRD PAGE

SMALLPOX—The only known way to control smallpox is by vaccination. Every child should be protected against smallpox by the time one year of age is reached.

* * *

In order to have your child given these immunizations, you should consult your family physician or local health department.

You should take this card with you and have the date entered in the proper space. School authorities often require such information on children entering school. The wise parent will keep this record for future use.

FOURTH PAGE

RECORD OF PREVENTIVE TREATMENT		
NAME _____		BIRTH DATE _____
ADDRESS _____		
FATHER'S NAME _____		
MOTHER'S NAME _____		
IMMUNIZING AGENT	DATE COMPLETED	PHYSICIAN'S NAME
WHOOPING COUGH		
DIPHTHERIA		
SMALLPOX		
KEEP THIS CARD		
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 115		

PURPOSE: To provide parents with a form on which a record may be kept of preventive treatments given their child, and the time that these preventive treatments should be given.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

COMMENT: This form will be mailed to parents from the Division of Vital Statistics, Tennessee Department of Public Health, along with a photostatic copy of the birth certificate. Parents should take this form with them when the child is inoculated and have the dates of the respective inoculations entered in the proper spaces.

A limited supply of these forms should be kept in the local health department in case parents lose their copies and wish to replace them, or in case the nurse wishes to emphasize the use of the form in her visits to the home.

Pages 116-119 missing

CERTIFICATE OF DEATH - FORM 120

SIZE 7 $\frac{1}{4}$ " x 9"

DEPARTMENT OF PUBLIC HEALTH		CERTIFICATE OF DEATH		DIVISION OF VITAL STATISTICS																																																																																																																																																													
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<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> <p>THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND WILL BE PLACED IN PERMANENT FILE.</p> <p>WRITE PLAINLY WITH PERMANENT INK OR TYPEWRITER.</p> <p>PHYSICIAN LAST IN ATTENDANCE MUST STATE CAUSE OF DEATH AND SIGN MEDICAL CERTIFICATION. IF NO PHYSICIAN IN ATTENDANCE, HEALTH OFFICER (OR CORONER, IF INQUEST WAS HELD) MUST COMPLETE AND SIGN MEDICAL CERTIFICATION. POWER OF SIGNATURE CANNOT BE DELEGATED.</p> <p>CAUSE OF DEATH. ENTER ONLY ONE CAUSE PER LINE FOR A, B, C. * THIS DOES NOT MEAN MODE OF DYING SUCH AS HEART FAILURE, ASTHMA, ETC. IT MEANS THE DISEASE, INJURY OR COMPLICATION WHICH CAUSED DEATH.</p> <p>FUNERAL DIRECTOR OR PERSON DISPOSING OF BODY, MUST FILE CERTIFICATE WITH LOCAL REGISTRAR WITHIN 72 HOURS AFTER DEATH AND PRIOR TO TRANSPORTATION BY COMMON CARRIER OR REMOVAL FROM STATE.</p> <p>ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.</p> </div> <div style="width: 80%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">1. NAME</td> <td colspan="4">2. DATE OF DEATH</td> </tr> <tr> <td colspan="2">FIRST MIDDLE LAST</td> <td colspan="4">MONTH DAY YEAR</td> </tr> <tr> <td>3. COLOR OR RACE</td> <td>4. SEX</td> <td>5. SINGLE, MARRIED, WIDOWED, DIVORCED (SPECIFY)</td> <td>6. DATE OF BIRTH</td> <td>7. AGE (IN YEARS LAST BIRTHDAY)</td> <td>8. IF UNDER 1 YR. MONTHS DAYS</td> </tr> <tr> <td colspan="3">9. PLACE OF DEATH</td> <td colspan="3">10. USUAL RESIDENCE OF DECEASED (Where Deceased Lived, If Institution, Residence Before Admission)</td> </tr> <tr> <td colspan="2">A. 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24. FUNERAL DIRECTOR ADDRESS		25. REGISTRATION DIST. NO.		26. DATE SIGNED BY LOCAL REG.																																																																																																																																																													
				27. REGISTRAR'S SIGNATURE																																																																																																																																																													

PURPOSE: To record data necessary for report and registration of a death and to serve local or deputy registrars as authority for issuing burial-transit permit (Form 128) for bodies to be cremated, transported by common carrier or removed from the State.

EXPLANATION AND DEFINITIONS: *Birth Number* and *Death Number* will be completed in the Division of Vital Statistics of the Tennessee Department of Public Health. The medical portion of the certificate must be signed by the attendant. Power of signature cannot be delegated to a secretary or other person.

USED BY: Private physicians, undertakers, local and deputy registrars, health department personnel, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: The undertaker, or person acting as such, is legally responsible for filing a *completed* death certificate with the local or deputy registrar where death actually occurred or was first discovered. On receipt of certificates, the clerk checks them for completeness and makes copies on summary cards (Form 121). No information for missing items is to be entered on the face of the certificate except by the person originally completing the certificate. Additional information, obtained from a reliable source, intended to furnish missing items or supplement information given, may be entered on the back of the certificate in ink *over the signature* (not initials) of the person giving the information (registrar, health officer, etc.). Without the signature, the information cannot be used. When it is necessary to obtain a new certificate, the person who signed the original certificate must sign the corrected certificate. If a new, corrected certificate is obtained and substituted, the registrar's name and the new filing date must be added to the substitute. *Altered* certificates will not be accepted. All certificates are due in the office of the Division of Vital Statistics on or before the *tenth* of the month.

COMMENT: The medical portion of all certificates must be signed by the physician last in attendance, stating cause of death, etc. If there was no medical attendant, the certificate is to be signed by the health officer, unless a coroner holds an inquest or investigation, in which case the coroner signs the certificate. A statement of cause of death is to be made, if possible. When the medical portion is signed by the health officer, give his title, "County Health Officer."

For details see *Vital Statistics Registration Manual*.

12-14-48

SUMMARY CARD - DEATH - FORM 121
SIZE 4" x 6"

NAME _____				CLASS _____	
LAST	FIRST	MIDDLE	DATE OF DEATH _____		
COLOR _____	SEX _____	MARITAL STATE _____	DATE OF BIRTH _____	AGE _____	YEARS _____ MONTHS _____ DAYS _____
PLACE OF DEATH: COUNTY _____		CIVIL DIST. _____	CITY OR TOWN _____	HOSPITAL _____	
USUAL RESIDENCE: STATE AND COUNTY _____		CIVIL DIST. _____	CITY OR TOWN _____	STREET ADDRESS _____	
OCCUPATION AND INDUSTRY _____		FATHER'S NAME _____		MOTHER'S MAIDEN NAME _____	
CAUSE OF DEATH					
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) _____		
MEDICAL CERTIFICATION	ANTECEDENT CAUSES		DUE TO (B) _____		
			DUE TO (C) _____		
OTHER					
2. SIGNIFICANT CONDITIONS					
OPERATION: DATE _____		FINDINGS _____		AUTOPSY FINDINGS _____	
ACCIDENT, SUICIDE, HOMICIDE? _____		PLACE OF INJURY _____		TIME OF INJURY _____	
HOW DID INJURY OCCUR? _____					
DATE RECORDED _____	FUNERAL DIRECTOR _____		PHYSICIAN _____		
SUMMARY CARD - DEATH				TENNESSEE DEPT. PUBLIC HEALTH 121	

PURPOSE: To provide an office record of a death which serves for reference and for study purposes.

EXPLANATION AND DEFINITIONS:

Date Recorded: Enter the date that the acceptable certificate is received in the county health department.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: The clerk makes one of these cards for each acceptable death certificate, or photostatic copy of certificate, received. These cards, filed alphabetically in two files--(1) current year, and (2) all other years--are used as an index and for special tabulations of deaths by month or year. Summary cards of deaths under one year of age are checked against summary cards of births and routine procedures followed for unreported births. Summary cards of deaths from notifiable diseases are checked against office report cards of notifiable diseases. (When a photostatic copy of a certificate is returned with a notation that the certificate was not accepted for filing and the date for filing the certificate has passed, the clerk makes similar notation on summary card in files.)

Cards for individuals dying in the area, but residing outside the area, are to be marked "non-resident." Cards made from photostatic copies of certificates for residents of the area dying outside the area are marked to distinguish them from cards for certificates originally routed through the local office.

COMMENT: This card assembles in summary form all data from death certificates which a local health department needs for monthly or annual tabulations.

UNREPORTED DEATH - FORM 122
SIZE 3" x 5"

Name _____	Date of Death _____
Place of Death _____	Color _____ Sex _____ Age _____
Residence _____	
Father _____	Mother _____
Attending Physician _____	
Undertaker _____	
Remarks _____	
Tennessee Department of Public Health No. 122	

PURPOSE: To furnish names of people dying for whom no death certificates have been received.

USED BY: Health department personnel.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

OFFICE MECHANICS AND FILING: Whenever a death is known to have occurred from checking newspaper notices, maternity, infant, notifiable disease records, or institutional report of death, funeral director and retail casket dealer reports, for which no death certificate is on file, a card must be prepared for use in investigating and reporting the death. All records with notation of death must be checked with the summary cards of death. If no summary card is located, this form must be completed. An attempt should be made to determine the undertaker and the doctor in attendance in order that the registrar may contact the undertaker and get a death certificate filed. If the registrar, after diligent effort, does not secure the certificate, he reports the violation to the State Registrar on Form 125.

It is essential that this file of unreported deaths be used constantly in order that the certificate may be filed before the end of the current year.

It is suggested that these cards for unreported deaths be kept together in the same file with the unreported birth cards.

Page 123 missing

INSTITUTIONAL REPORT OF DEATHS AND STILLBIRTHS - FORM 124
SIZE 11" x 8½"

[illegible]

PURPOSE: To furnish the local registrar and Division of Vital Statistics with a means of discovering unreported deaths and stillbirths.

EXPLANATION AND DEFINITIONS: The local registrar is responsible for distributing and collecting these forms. Each superintendent, manager, or other person in charge of a hospital, almshouse, lying-in or other institution, public or private, including penal institutions, to which persons resort for treatment of disease, injury, or childbirth, or are committed by process of law, is required to complete this form and submit it to the local registrar on the first day of each month.

The local registrar must check this list against the death and stillbirth certificates for that month, attempt to secure certificates for unreported deaths and stillbirths, and send the list to the Division of Vital Statistics with the monthly report.

COMMENT: For detailed instructions see Vital Statistics Registration Manual.

REPORT OF FAILURE TO FILE DEATH CERTIFICATE - FORM 125
SIZE 11" x 8½"

STATE OF TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF VITAL STATISTICS	
REPORT OF FAILURE TO FILE DEATH CERTIFICATE	
NAME: _____	
DATE OF DEATH: _____	AT APPROXIMATELY _____ M.
SEX: _____ COLOR OR RACE _____	
PLACE OF DEATH: COUNTY _____ CIVIL DISTRICT _____	
CITY OR TOWN _____	
HOSPITAL OR STREET ADDRESS _____	
NAME AND ADDRESS OF UNDERTAKER: _____	
PLACE OF BURIAL: _____ DATE OF BURIAL _____	
DID THE UNDERTAKER SECURE THE INFORMATION NECESSARY FOR PREPARING A CERTIFICATE? _____	
WHO WAS THE LAST DOCTOR IN ATTENDANCE BEFORE DEATH? _____	
WHEN DID HE LAST ATTEND THE DECEASED? _____	
DID UNDERTAKER PRESENT CERTIFICATE FOR SIGNATURE OF DOCTOR? _____	
WHAT WAS HIS DIAGNOSIS? _____	
NAMES AND ADDRESSES OF OTHER PERSONS WHO HAD KNOWLEDGE OF THIS DEATH _____	

STATE DATES AND EFFORTS MADE TO SECURE THIS CERTIFICATE: _____	

REMARKS: _____	

I hereby certify that the foregoing facts are true and correct to the best of my knowledge and belief.	
SIGNED _____	LOCAL REGISTRAR
DATE _____	
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 125	

PURPOSE: To provide formal notification to Division of Vital Statistics by local registrars that a violation of the vital statistics law has occurred in the jurisdiction from which the report is made.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Local registrar, Division of Vital Statistics.

OFFICE USE AND FILING MECHANICS:

Violation by Funeral Directors: If a certificate has not been filed after reasonable attempts have been made by the registrar to obtain it, complete data should be given on this form. Complete and accurate details are necessary for proper checking in the Division of Vital Statistics, to see that the certificate in question is not already on file.

COMMENT: This requirement is not optional with registrars, but is mandatory.

For details see Vital Statistics Registration Manual.

REQUEST FOR A CERTIFIED COPY OF A DEATH CERTIFICATE -- FORM 126
 size 5½" x 8½"

FRONT

TO: TENNESSEE DEPT. OF PUBLIC HEALTH DIVISION OF VITAL STATISTICS NASHVILLE, TENN.		DO NOT WRITE IN THIS SPACE	
REQUEST FOR A CERTIFIED COPY OF A DEATH CERTIFICATE:			
FULL NAME OF DECEASED:		NAME	
DATE OF DEATH: COLOR: SEX:		CERTIFICATE NO.	
PLACE OF DEATH (TOWN): (COUNTY): (CIVIL DIST.):		VOL. NO.	
UNDERTAKER IN CHARGE:		CERT. COPY NO.	
SEND TO:		DATE ISSUED	
FEE ATTACHED (AMOUNT) M. O. () CASH ()		FORM 126	
PLEASE NOTE INSTRUCTIONS ON BACK			

BACK

INSTRUCTIONS

Be sure to give full name, correctly spelled.

A fee of one dollar (\$1.00), in advance, is required for each certified copy requested.

If the death occurred within thirty days of the date of this request, please give full information concerning place of death, and name of undertaker. The certificate may not have reached this office, and it will be necessary to write the local registrar of the district where death occurred to secure it.

See instructions for Request for a Certified Copy of a Certificate of Birth, Form 106.

APPLICATION FOR DISINTERMENT PERMIT - FORM 127
SIZE 7¼" x 8¼"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR DISINTERMENT PERMIT

APPLICATION IS HEREBY MADE TO DISINTER AND REMOVE THE BODY OF _____
WHO DIED ON _____, AND WHO IS NOW BURIED IN _____ CEMETERY.
CIVIL DISTRICT NO. _____ OF _____ COUNTY, TENNESSEE. THE BODY IS TO BE
REMOVED TO _____ STATE OF _____ FOR REINTERMENT.
REMOVAL IS TO BE MADE BY _____
(RAILROAD, HEARSE, ETC.)

I HEREBY AGREE TO ABIDE BY ALL RULES AND REGULATIONS OF THE TENNESSEE DEPARTMENT
OF PUBLIC HEALTH, AND THOSE OF THE STATE TO WHICH THE BODY IS TO BE REMOVED, IN REGARD
TO PREPARATION OF THE INTERRED REMAINS, AND CONTAINER, AND IN THE TRANSPORTATION OF SAME.

UNDERTAKER (OR PERSON ACTING AS SUCH) ADDRESS _____

PERMIT

PERMISSION IS HEREBY GRANTED TO _____ TO DISINTER THE BODY
OF THE DECEASED PERSON NAMED ABOVE.

M.D.

ADDRESS _____

DATE _____ COUNTY HEALTH OFFICER OF _____ COUNTY

OVER

FORM 127

BACK

RULES AND REGULATIONS GOVERNING DISINTERMENT OF DEAD BODIES

1. THE FUNERAL DIRECTOR, OR ACTING FUNERAL DIRECTOR, SHOULD COMPLETE AND SIGN THE UPPER PART OF THE DISINTERMENT PERMIT, AND PRESENT IT TO THE HEALTH OFFICER OF THE COUNTY WHERE THE BODY IS BURIED.
2. IF THE HEALTH OFFICER APPROVES, HE WILL SIGN THE LOWER PART OF THE PERMIT.
3. THE COMPLETED PERMIT SHOULD BE FILED IMMEDIATELY BY THE FUNERAL DIRECTOR WITH THE REGISTRAR OF THE COUNTY IN WHICH THE BODY IS BURIED.
4. IF DISINTERRED BODY IS TO BE CREMATED, TRANSPORTED BY COMMON CARRIER, OR REMOVED FROM THE STATE, THE REGISTRAR OF THE COUNTY IN WHICH THE BODY IS BURIED WILL ISSUE A BURIAL-TRANSIT PERMIT, (FORM 128) FOR THIS DISPOSAL.
5. THE REGISTRAR MUST INCLUDE THE DISINTERMENT PERMIT WITH THE CURRENT MONTHLY REPORT TO THE DIVISION OF VITAL STATISTICS.

PREPARATION FOR TRANSPORTATION AND REINTERMENT OF DISINTERRED REMAINS

1. WHEN THE REMAINS ARE FOUND TO BE ONLY BONES AND DUST, THESE MAY BE ENCLOSED IN A WOODEN BOX.
2. WHEN THE ORIGINAL CASKET IN WHICH THE BODY WAS BURIED IS INTACT AND IN SUITABLE CONDITION FOR BEING REMOVED AND REINTERRED WITHOUT BEING OPENED, IT MAY BE ENCLOSED IN A WOODEN BOX.
3. IN ANY CASE WHERE THERE IS ESCAPE OF ODORS OR LIQUIDS, ALL DISINTERRED REMAINS MUST, IMMEDIATELY UPON DISINTERMENT, BE ENCLOSED IN A METAL CONTAINER AND ALL JOINTS AND SEAMS MUST BE HERMETICALLY SEALED AND ALL ENCLOSED IN A STRONG OUTSIDE WOODEN BOX.

APPLICATION FOR DISINTERMENT PERMIT - FORM 127

PURPOSE: To provide a record of application for disinterment and permit for removal of a body from its original place of interment.

USED BY: Funeral director, health officer, registrar.

EXPLANATION AND DEFINITIONS: Self-explanatory.

OFFICE MECHANICS AND FILING: The face of the form showing data relative to the deceased is to be completed and the agreement signed by the undertaker or person acting as such. The permission of health officer of the locality where the body is buried is required. The completed application is presented to the local or deputy registrar of the district in which the body is buried and is used as the basis of burial-transit permit (Form 128), when the remains are to be cremated, transported by common carrier or removed from the State. The completed Form 127 is forwarded to the Division of Vital Statistics with next report of birth, death, and stillbirth certificates.

COMMENT: After obtaining burial-transit permit (Form 128) the undertaker fills out that part of the permit (lower section) pertaining to disinterred bodies and uses it in the same manner as ordinary burial-transit permits.

11-3-47

BURIAL-TRANSIT PERMIT - FORM 128

SIZE 4 $\frac{1}{4}$ " x 11"

BURIAL-TRANSIT PERMIT		DEPT. OF PUBLIC HEALTH STATE OF TENNESSEE DIV. OF VITAL STATISTICS	
PERMIT NO. _____ NAME _____ PLACE OF DEATH _____ DATE OF DEATH _____ COL. _____ AGE _____ SEX _____ PLACE OF BURIAL _____ CEMETERY _____ ADDRESS _____ UNDERTAKER _____ ADDRESS _____ DATE ISSUED _____ BY _____ IF DISINTERMENT _____ DATE OF DISINTERMENT _____ REMOVAL TO _____ UNDERTAKER _____ <small>THIS STUB TO BE COMPLETELY FILLED OUT AND RETAINED BY LOCAL REGISTRAR.</small>	THIS PERMIT MUST ACCOMPANY BODY TO DESTINATION	<div style="text-align: center; font-weight: bold;">BURIAL-TRANSIT PERMIT</div> <div style="text-align: right;">No. _____</div> FULL NAME OF DECEASED _____ AGE _____ SEX _____ COL. _____ PLACE OF DEATH CITY _____ COUNTY _____ DATE OF DEATH _____ IS _____ CAUSE OF DEATH _____ METHOD OF DISPOSAL (BURIAL, CREMATION, TRANSIT) _____ CEMETERY _____ PLACE _____ UNDERTAKER _____ ADDRESS _____ <div style="text-align: center; font-weight: bold;">PERMIT</div> A CERTIFICATE OF DEATH HAVING BEEN FILED AS REQUIRED BY TENNESSEE LAW, PERMISSION IS HEREBY GIVEN TO _____, UNDERTAKER, TO DISPOSE OF THE BODY AS STATED. DATE _____ IS _____ REGISTRATION DIST. NO. _____ SIGNATURE _____ REGISTRAR _____ <div style="text-align: center; font-weight: bold;">CEMETERY (OR CREMATORY) AUTHORITY SHALL FILL OUT SPACE BELOW</div> BODY WAS _____ ON _____ IS _____ IN _____ CEMETERY _____ <small>(BURIED, CREMATED)</small> <small>(OR CREMATORY)</small> PLACE _____ SIGNATURE (SECTION) _____ THIS PERMIT TO BE COMPLETED AND USED ALSO IN REMOVAL OF DISINTERRED BODIES. ISSUED ON RECEIPT OF DISINTERMENT PERMIT. DATE OF DISINTERMENT _____ IS _____ REMOVAL TO _____ CEMETERY _____ ADDRESS _____ BY _____ UNDERTAKER _____ <div style="display: flex; justify-content: space-between;"> FORM 128 INSTRUCTIONS ON REVERSE SIDE MUST BE OBSERVED </div>	

REGISTRAR: THIS PERMIT TO BE ISSUED ONLY UPON RECEIPT OF:

1. DEATH OR STILLBIRTH CERTIFICATE
2. A DISINTERMENT PERMIT

FUNERAL DIRECTOR: THIS PERMIT IS OBTAINED IN ONLY THREE INSTANCES:

1. FOR CREMATION OF A DEAD BODY OR DISINTERRED REMAINS.
2. FOR TRANSPORTATION BY COMMON CARRIER OF A DEAD BODY OR DISINTERRED REMAINS OR, AFTER CREMATION, THE ASHES THEREOF, OF EITHER.
3. FOR REMOVAL FROM THE STATE OF A DEAD BODY OR DISINTERRED REMAINS OR, AFTER CREMATION, THE ASHES THEREOF, OF EITHER.

WHEN USED AS A TRANSIT PERMIT FOR TRANSPORTATION BY COMMON CARRIER, THIS PERMIT TO BE ENCLOSED IN A STRONG ENVELOPE ATTACHED TO SHIPPING CASE. BODY MUST BE PREPARED ACCORDING TO REGULATIONS GOVERNING TRANSPORTATION OF BODIES.

PURPOSE: To provide legal authorization for disposal of body by cremation, transportation by common carrier or removal from the State.

EXPLANATION AND DEFINITIONS: Certain explanatory items appear on back of form. (For detailed instructions, see Vital Statistics Registration Manual.)

USED BY: Local and deputy registrars, clerk, funeral director, sexton, crematory authority.

OFFICE MECHANICS AND FILING: On receipt of properly executed death certificate (Form 120) or stillbirth certificate (Form 140), or Application for Disinterment (Form 127), the registrar issues burial-transit permit to the undertaker or person acting as such. The registrar should retain the burial-transit permit after it is returned to him.

COMMENT: The clerk of the health department, acting for health officer (in his capacity as registrar or deputy registrar), should be prepared to issue burial-transit permits for area assigned. The file date is added to death certificate by the clerk and the certificate forwarded to the proper registrar. Burial-transit permit should not be issued after disposal of the body, as, by this action, the person acting as registrar condones and becomes a party to the violation of the law. Such cases should be reported by the registrar to the Division of Vital Statistics, on Form 125.

DELAYED REPORT OF DIAGNOSIS - FORM 129
SIZE 6¼" x 8¼"

NOTE CAREFULLY THIS DELAYED REPORT OF DIAGNOSIS MUST BE FILED WITHIN TEN (10) DAYS AFTER DEATH.—THIS IS A PERMANENT LEGAL RECORD USE TYPEWRITER OR WRITE LEGIBLY WITH UNFADING INK	DEPT. OF PUBLIC HEALTH STATE OF TENNESSEE DIV. OF VITAL STATISTICS		
	DELAYED REPORT OF DIAGNOSIS		
	FULL NAME OF DECEASED _____		
	FIRST	MIDDLE	LAST
	DATE OF DEATH _____ SEX _____ COLOR OR RACE _____		
	PLACE OF DEATH: _____		
	COUNTY _____ CIVIL DIST. _____ CITY OR TOWN _____		
	IF OUTSIDE CITY LIMITS, WRITE RURAL _____		
	MEDICAL CERTIFICATION		
	I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM _____ 19____ TO _____ 19____ AND THAT I LAST SAW HIM ALIVE ON _____ 19____ AND THAT DEATH OCCURRED ON THE DATE STATED AT _____ M. IMMEDIATE CAUSE OF DEATH: _____		
		DURATION	
DUE TO: _____			
OTHER CONDITIONS: _____ <small>(INCLUDE PREGNANCY WITHIN 3 MONTHS OF DEATH)</small>			
OPERATION? _____	FINDINGS _____	PHYSICIAN UNDERLINE CAUSE TO WHICH DEATH SHOULD BE CHARGED STATISTICALLY	
AUTOPSY? _____	FINDINGS _____		
I ALSO CERTIFY THAT THE CAUSE OF DEATH COULD NOT BE DETERMINED WITHIN SEVENTY-TWO (72) HOURS AFTER DEATH AND ENTERED ON THE CERTIFICATE OF DEATH OF THE ABOVE PERSON, BECAUSE _____ _____ _____			
SIGNATURE _____ ADDRESS _____ DATE _____			

PURPOSE: To provide a means of obtaining a medical certification of the cause of death when the cause of death could not be determined within 72 hours after death.

EXPLANATION AND DEFINITIONS: Same as medical certification of death certificate except for lower section. The reason for not being able to determine cause of death within 72 hours after death should always be clearly stated.

USED BY: Attending physician, health officer, coroner, funeral director, local registrar, health department clerk.

OFFICE MECHANICS AND FILING: If the cause of death has not been determined in time to include on the death certificate, a Delayed Report of Diagnosis must be filed with the funeral director by the attending physician, county health officer or coroner. The funeral director must then file the Delayed Report of Diagnosis with the local registrar of the district where the original certificate was filed. The report must be made not later than 10 days after death occurred.

The clerk should enter the cause of death on the death summary card, indicate that it came from a Delayed Report of Diagnosis, and send the Delayed Report to the Division of Vital Statistics with the month's report.

MONTHLY REPORT OF FUNERAL DIRECTORS AND RETAIL CASKET DEALERS - FORM 130
 SIZE 8½" x 11"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF VITAL STATISTICS						
MONTHLY REPORT OF FUNERAL DIRECTORS AND RETAIL CASKET DEALERS						
MONTH OF _____ 194__						
This report shall include all caskets and other receptacles to be used in the disposal of a dead body which have been sold, donated or otherwise disposed of during the period stated. If none have been disposed of, report "none."						
FULL NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH		COLOR OR RACE	FUNERAL DIRECTOR OR PERSON ACTING AS SUCH NAME AND ADDRESS	PHYSICIAN LAST IN ATTENDANCE NAME AND ADDRESS
		COUNTY	STATE			

I hereby certify that a blank certificate of death and a casket notice (form 134) was enclosed in each receptacle disposed of except when this firm had charge of the disposal of the deceased, and that the above is a complete list of the sales, donations, or other disposals of receptacles for use in the disposal of dead bodies made by this firm during the above month.

SIGNED _____ BY: _____
 FIRM NAME _____

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 130

PURPOSE: To furnish the local registrar, the local health department, and the Division of Vital Statistics with a means of discovering unreported deaths.

USED BY: Funeral director, retail casket dealer, local and deputy registrars, Division of Vital Statistics.

EXPLANATION AND DEFINITIONS: The local registrar is responsible for distributing these forms and for receiving the completed ones on the first of each month. The registrar must check the names on the list against the death and stillbirth certificates and must attempt to collect delinquent certificates. This form must be included with his monthly report to the Division of Vital Statistics.

For deaths occurring in the county for whom no certificates are on file, unreported death cards must be made and certificates secured.

COMMENT: For detailed instructions see Vital Statistics Registration Manual.

CASKET NOTICE - FORM 131

SIZE 11" x 8½"

IMPORTANT—READ CAREFULLY**CASKET NOTICE**

The laws of Tennessee require that the undertaker, or person acting as such, or the person in charge of interment, shall file a complete certificate of death or stillbirth with the local registrar of the registration district in which the death or stillbirth occurred within 72 hours after the death or stillbirth, but in every instance prior to transportation by common carrier or removal from the State.

The undertaker, or person acting as such, shall fill in items 1 through 19 of the death or stillbirth certificate, except item 17, which shall be signed by the person giving him the information. The certificate shall then be presented to the doctor last in attendance on the deceased for certification of the cause of death over his signature. The completed certificate is then filed with the local registrar. If no doctor attended the deceased during his last illness, the undertaker, or person acting as such, shall notify the local registrar **BEFORE DISPOSING OF THE BODY BY BURIAL OR OTHERWISE**. Failure to do so is punishable by fine not to exceed one hundred dollars.

A BURIAL-TRANSIT PERMIT must be obtained from the local registrar of the registration district in which the death or stillbirth occurred before a dead body is CREMATED, TRANSPORTED BY COMMON CARRIER, or REMOVED FROM THE STATE. Such permit is not required for local burial.

THE TERM, "PERSON ACTING AS SUCH, OR PERSON IN CHARGE OF INTERMENT," REFERS TO ANY PERSON OR PERSONS WHO DISPOSE OF A DEAD BODY WHEN NO REGULAR UNDERTAKER IS IN CHARGE.

Failure to file a certificate of death is a violation of Chapter 23, Public Acts of 1941, and is punishable by a fine of not more than one hundred dollars.

The records of death are necessary for ascertaining the health conditions of each community, and for the protection of the people, by preventing the spread of contagious or infectious diseases. These records are valuable for legal purposes, and are often required in the settlement of estates, etc.

THE ORIGINAL RECORD OF EACH BIRTH AND DEATH IS FORWARDED BY THE LOCAL REGISTRAR TO THE DIVISION OF VITAL STATISTICS, TENNESSEE DEPARTMENT OF PUBLIC HEALTH, WHERE IT WILL BE PERMANENTLY PRESERVED.

FORM 131

PURPOSE: To remind every one who has charge of an interment that a completed death or stillbirth certificate must be filed within 72 hours after the death or stillbirth occurred.

USED BY: Retail casket dealer or maker.

EXPLANATION AND DEFINITIONS: One of these notices is placed in every casket or coffin disposed of for burial purposes where seller does not have charge of the burial.

Pages 133-139 missing

CERTIFICATE OF STILLBIRTH - FORM 140
SIZE 7 $\frac{1}{4}$ " x 9"

CERTIFICATE OF STILLBIRTH DEPARTMENT OF PUBLIC HEALTH - STATE OF TENNESSEE - DIVISION OF VITAL STATISTICS COOPERATING WITH NATIONAL OFFICE OF VITAL STATISTICS	
STILLBIRTH NO. _____	
1. NAME OF CHILD <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div>	
2. SEX <div style="display: flex; justify-content: space-between;"> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> </div>	3A. THIS BIRTH <div style="display: flex; justify-content: space-between;"> SINGLE <input type="checkbox"/> TWIN <input type="checkbox"/> TRIPLET <input type="checkbox"/> </div>
3B. IF TWIN OR TRIPLET, THIS CHILD BORN <div style="display: flex; justify-content: space-between;"> 1ST <input type="checkbox"/> 2ND <input type="checkbox"/> 3RD <input type="checkbox"/> </div>	
4. DATE OF BIRTH <div style="display: flex; justify-content: space-between;"> MONTH DAY YEAR </div>	
5. PLACE OF BIRTH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. COUNTY C. CITY (IF OUTSIDE CITY LIMITS WRITE RURAL) OR TOWN D. NAME OF (IF NOT IN HOSPITAL, GIVE STREET ADDRESS AND LOCATION) HOSPITAL </div> <div style="width: 55%;"> B. CIVIL DISTRICT A. STATE B. COUNTY C. CIVIL DISTRICT D. CITY (IF OUTSIDE CITY LIMITS, WRITE RURAL) OR TOWN E. STREET (IF RURAL, GIVE LOCATION) ADDRESS </div> </div>	
6. USUAL RESIDENCE OF MOTHER (WHERE DOES MOTHER LIVE?) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. COUNTY C. CITY (IF OUTSIDE CITY LIMITS WRITE RURAL) OR TOWN D. NAME OF (IF NOT IN HOSPITAL, GIVE STREET ADDRESS AND LOCATION) HOSPITAL </div> <div style="width: 55%;"> B. CIVIL DISTRICT A. STATE B. COUNTY C. CIVIL DISTRICT D. CITY (IF OUTSIDE CITY LIMITS, WRITE RURAL) OR TOWN E. STREET (IF RURAL, GIVE LOCATION) ADDRESS </div> </div>	
FATHER OF CHILD	
7. FULL NAME <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div>	
8. COLOR OR RACE	
9. AGE (AT TIME OF THIS BIRTH) <div style="display: flex; justify-content: space-between;"> YEARS </div>	10. BIRTHPLACE (State or Foreign Country)
11A. USUAL OCCUPATION	
11B. KIND OF BUSINESS OR INDUSTRY	
MOTHER OF CHILD	
12. FULL MAIDEN NAME <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div>	
13. COLOR OR RACE	
14. AGE (AT TIME OF THIS BIRTH) <div style="display: flex; justify-content: space-between;"> YEARS </div>	15. BIRTHPLACE (State or Foreign Country)
16A. USUAL OCCUPATION	
16B. KIND OF BUSINESS OR INDUSTRY	
17. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (DO NOT INCLUDE THIS CHILD)	
A. HOW MANY CHILDREN ARE NOW LIVING?	
B. HOW MANY CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD?	
C. HOW MANY OTHER CHILDREN WERE STILLBORN (BORN DEAD AFTER 20 WEEKS OF PREGNANCY)?	
18A. LENGTH OF PREGNANCY <div style="display: flex; justify-content: space-between;"> WEEKS </div>	18B. WEIGHT AT BIRTH <div style="display: flex; justify-content: space-between;"> POUNDS OUNCES </div>
19. LEGITIMATE <div style="display: flex; justify-content: space-between;"> YES <input type="checkbox"/> NO <input type="checkbox"/> </div>	
20. DID CHILD DIE BEFORE LABOR? <div style="display: flex; justify-content: space-between;"> YES <input type="checkbox"/> NO <input type="checkbox"/> </div>	
21. CAUSE OF STILLBIRTH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. HOW MANY CHILDREN ARE NOW LIVING? B. HOW MANY CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD? C. HOW MANY OTHER CHILDREN WERE STILLBORN (BORN DEAD AFTER 20 WEEKS OF PREGNANCY)? </div> <div style="width: 55%;"> 21A. FETAL CAUSES 21B. MATERNAL CAUSES </div> </div>	
22. STATE ANY COMPLICATIONS OF PREGNANCY AND LABOR	
23. STATE ALL OPERATIONS FOR DELIVERY	
24. SIGNATURE <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. I HEREBY CERTIFY THAT THIS CHILD WAS BORN DEAD ON DATE STATED ABOVE. NAME _____ C. ADDRESS _____ </div> <div style="width: 55%;"> B. ATTENDANT AT BIRTH M.D. <input type="checkbox"/> MIDWIFE <input type="checkbox"/> OTHER (SPECIFY) _____ IF NOT ATTENDED BY PHYSICIAN 25. SIGNATURE OF HEALTH OFFICER OR CORONER </div> </div>	
26A. BURIAL, CREMATION OR REMOVAL	26B. DATE OF BURIAL, CREMATION OR REMOVAL
26C. NAME OF CEMETERY OR CREMATORY	26D. LOCATION CITY, TOWN OR COUNTY STATE
27. FUNERAL DIRECTOR ADDRESS	28. REGISTRATION DIST. NO.
29. DATE RECEIVED BY LOCAL REG.	30. REGISTRAR'S SIGNATURE

PURPOSE: To record data necessary for reporting and registration of a stillbirth and to serve local registrars as authority for issuing burial-transit permit (Form 128), when body is to be cremated, transported by common carrier or removed from the state.

EXPLANATION AND DEFINITIONS: *Stillbirth Number* will be assigned in the Division of Vital Statistics of the Tennessee Department of Public Health. The medical portion of the certificate must be signed by the attendant. Power of signature cannot be delegated to a secretary or other person.

If the stillbirth was attended by someone other than a person legally authorized to practice obstetrics, the certificate must be signed by the county health officer or coroner.

USED BY: Private physician, county health officer, coroner, midwife, funeral director, registrar, clerk, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: The funeral director, or person acting as such, is legally responsible for filing the *completed* certificate with the local or deputy registrar where the stillbirth occurred. The attending physician, midwife or other person who attended the stillbirth signs the certificate. When a stillbirth occurs without medical attendance, or is attended by a midwife, the medical portion of the certificate is to be signed by the health officer, also.

The certificates are due in the local registrar's office within 72 hours after stillbirth occurred. The clerk checks the certificate for completeness and makes copies on the stillbirth summary cards (Form 141). They are due in the Division of Vital Statistics by the *tenth* of the following month.

COMMENT: No certificate is required for a fetus of less than twenty weeks utero-gestation. A definition of stillbirth is on the left hand margin of the certificate.

For details see *Vital Statistics Registration Manual*.

12-14-48

SUMMARY CARD - STILLBIRTH - FORM 141
SIZE 4" x 6"

NAME _____			
LAST	FIRST	MIDDLE	
COLOR _____	SEX _____	SINGLE OR PLURAL _____	DATE OF BIRTH _____
PLACE OF BIRTH: COUNTY _____	CIVIL DIST. _____	CITY OR TOWN _____	HOSPITAL _____
USUAL RESIDENCE: COUNTY _____	CIVIL DIST. _____	CITY OR TOWN _____	STREET ADDRESS _____
FATHER _____	AGE _____	OCCUPATION AND INDUSTRY _____	
MOTHER _____	AGE _____	OCCUPATION AND INDUSTRY _____	
CHILDREN PREVIOUSLY BORN TO THIS MOTHER _____	A. HOW MANY CHILDREN ARE NOW LIVING? _____	B. HOW MANY CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD? _____	C. HOW MANY OTHER CHILDREN WERE STILLBORN (BORN DEAD)? _____
LENGTH OF PREGNANCY _____ WKS.; WEIGHT AT BIRTH _____ LBS. _____ OZS.; LEGITIMATE: YES <input type="checkbox"/> NO <input type="checkbox"/>			
FETAL CAUSE _____			
MATERNAL CAUSE _____			
COMPLICATIONS _____		OPERATIONS _____	
DATE RECORDED _____	FUNERAL DIRECTOR _____	ATTENDANT _____	<input type="checkbox"/> M.D. <input type="checkbox"/> MIDWIFE <input type="checkbox"/> OTHER
SUMMARY CARD - STILLBIRTH TENNESSEE DEPARTMENT PUBLIC HEALTH - 141			

PURPOSE: To provide an office record of a stillbirth which serves for reference and for study purposes.

EXPLANATION AND DEFINITIONS:

Date Recorded: Enter the date that the acceptable certificate is received in the county health department office.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: The clerk makes one of these cards for each acceptable stillbirth certificate, or photostatic copy of certificate, received. These cards, filed alphabetically in two files--(1) current year, and (2) all other years--are used as an index and for special tabulations of stillbirths by month or year. Cards for infants stillborn in the area to mothers residing outside the area served by the health department are marked "non-resident." Cards made from the photostatic copies of certificates for infants stillborn outside the area to mothers residing in the area are marked to distinguish them from cards for certificates originally routed through the local office. (When a photostatic copy of a certificate is received with a notation that the certificate was not accepted for filing and the date for filing certificate has passed, clerk makes similar notation on summary cards in file.)

COMMENT: This card assembles in summary form all data from stillbirth certificate which the local health department needs for monthly and annual tabulation.

Pages 142-155 missing

REQUEST FOR A CERTIFIED COPY OF A CERTIFICATE OF MARRIAGE - FORM 156
size 5½" x 8½"

FRONT

REQUEST FOR CERTIFIED COPY OF CERTIFICATE OF MARRIAGE			
TO: DIVISION OF VITAL STATISTICS TENNESSEE DEPARTMENT OF PUBLIC HEALTH 420 SIXTH AVENUE, NORTH NASHVILLE 3, TENNESSEE		DATE _____	
PLEASE SEARCH YOUR RECORDS FOR THE CERTIFICATE OF MARRIAGE FOR THE PARTIES NAMED BELOW:			
FULL NAME OF GROOM: _____		_____	
FIRST	MIDDLE	SURNAME	
FULL NAME OF BRIDE: _____		_____	
FIRST	MIDDLE	MAIDEN SURNAME	
DATE OF MARRIAGE: _____			
COUNTY IN WHICH LICENSE WAS ISSUED: _____			
NAME OF OFFICIANT: _____			
SIGNED: _____			
ADDRESS: _____			
FEE FOR MAKING SEARCH		\$	1 00
FIRST CERTIFIED COPY (NO EXTRA CHARGE IF CERTIFICATE IS ON FILE)		\$	00
ADDITIONAL CERTIFIED COPIES @ \$1.00 EACH		\$	
ENCLOSED FIND MY REMITTANCE FOR		\$	

PLEASE NOTE INSTRUCTIONS ON BACK

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 156

BACK

INSTRUCTIONS
<p>Give complete information as listed. Use typewriter, if possible, or print plainly. If exact date of marriage is unknown, give the approximate date.</p> <p>If the marriage occurred within thirty days of the date of this request and the certificate has not been filed, it will be necessary for this office to secure the certificate from the County Court Clerk of the county where the license was issued before the certified copy is issued.</p> <p>Registration of Certificates of Marriage began in Tennessee on July 1, 1945. No certificate of Marriage is on file for a marriage performed prior to July 1, 1945.</p> <p>Remittance for each certified copy should be sent by money order. Personal checks will not be accepted. DO NOT SEND CASH.</p>

See instructions for Request for a Certified Copy of a Certificate of Birth, Form 106

Pages 157-165 missing

REQUEST FOR A CERTIFIED COPY OF A CERTIFICATE OF DIVORCE - FORM 166
 SIZE 5½" x 8½"

FRONT

REQUEST FOR CERTIFIED COPY OF CERTIFICATE OF DIVORCE											
TO: DIVISION OF VITAL STATISTICS TENNESSEE DEPARTMENT OF PUBLIC HEALTH 420 SIXTH AVENUE, NORTH NASHVILLE 3, TENNESSEE			DATE _____								
PLEASE SEARCH YOUR RECORDS FOR THE CERTIFICATE OF DIVORCE FOR THE PARTIES NAMED BELOW:											
FULL NAME OF HUSBAND: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> FIRST MIDDLE SURNAME </div>											
FULL NAME OF WIFE: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> FIRST MIDDLE MAIDEN SURNAME </div>											
DATE OF DIVORCE: _____											
COUNTY OF DIVORCE: _____											
NAME OF COURT: _____											
SIGNED: _____											
ADDRESS: _____											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: x-small;">FEE FOR MAKING SEARCH</td> <td style="text-align: right; font-size: x-small;">\$ 1.00</td> </tr> <tr> <td style="font-size: x-small;">FIRST CERTIFIED COPY (NO EXTRA CHARGE IF CERTIFICATE IS ON FILE)</td> <td style="text-align: right; font-size: x-small;">.00</td> </tr> <tr> <td style="font-size: x-small;">ADDITIONAL CERTIFIED COPIES @ \$1.00 EACH</td> <td style="text-align: right; font-size: x-small;">\$</td> </tr> <tr> <td style="font-size: x-small;">ENCLOSED FIND MY REMITTANCE FOR</td> <td style="text-align: right; font-size: x-small;">\$</td> </tr> </table>		FEE FOR MAKING SEARCH	\$ 1.00	FIRST CERTIFIED COPY (NO EXTRA CHARGE IF CERTIFICATE IS ON FILE)	.00	ADDITIONAL CERTIFIED COPIES @ \$1.00 EACH	\$	ENCLOSED FIND MY REMITTANCE FOR	\$		
FEE FOR MAKING SEARCH	\$ 1.00										
FIRST CERTIFIED COPY (NO EXTRA CHARGE IF CERTIFICATE IS ON FILE)	.00										
ADDITIONAL CERTIFIED COPIES @ \$1.00 EACH	\$										
ENCLOSED FIND MY REMITTANCE FOR	\$										
PLEASE NOTE INSTRUCTIONS ON BACK											
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 166											

BACK

INSTRUCTIONS
<p>Give complete information as listed. Use typewriter, if possible, or print plainly. If exact date of divorce is unknown, give the approximate date.</p> <p>If the divorce occurred within thirty days of the date of this request and the certificate has not been filed, it will be necessary for this office to secure the certificate from the clerk of the court of the county where the divorce was granted before the certified copy is issued.</p> <p>Registration of Certificate of Divorce began in Tennessee on July 1, 1945. No certificate of Divorce is on file for a divorce granted prior to July 1, 1945.</p> <p>Remittance for each certified copy should be sent by money order. Personal checks will not be accepted. DO NOT SEND CASH.</p>

See instructions for Request for a Certified Copy of a Certificate of Birth, Form 106.

Pages 167-171 missing

REGISTER ADDITIONS, CORRECTIONS, REMOVALS - FORM 172
size 5½" x 8½"

COUNTY _____					
REPORT TO DIVISION OF VITAL STATISTICS FOR REGISTER ADDITIONS, CORRECTIONS, REMOVALS					
ADDITIONS					
FULL NAME [#]	TITLE [*]	PRESENT ADDRESS	FORMER ADDRESS		
CORRECTIONS					
INFORMATION SHOWN ON REGISTER			INFORMATION TO BE SHOWN ON REGISTER		
FULL NAME [#]	TITLE [*]	ADDRESS	FULL NAME [#]	TITLE [*]	ADDRESS
REMOVALS					
FULL NAME [#]	TITLE [*]	ADDRESS	REASON FOR REMOVAL (DECEASED - RETIRED - MOVED FROM STATE)		
<small># DO NOT ENTER INITIALS FOR GIVEN NAMES * INDICATE M.D., OSTEOPATH, CHIROPRACTOR, MIDWIFE, UNDERTAKER</small>			SIGNATURE OF LOCAL REGISTRAR _____ DATE _____		
<small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 172</small>					

PURPOSE: To provide a form sufficiently detailed for the accurate amendment of lists of practitioners of the healing arts and funeral directors, morticians and undertakers on file in the Division of Vital Statistics.

EXPLANATION AND DEFINITIONS:

According to Law: Practitioners of the healing arts and funeral directors, morticians or undertakers are required to register with the Tennessee Department of Public Health.

According to Regulations:

1. The State Registrar is required to furnish each local registrar a list of persons registered.
2. The local registrar is required to check the list furnished for accuracy of names and addresses of all persons, firms, or corporations in his district and immediately notify the state registrar of errors in original list.
3. The local registrar is required to notify the state registrar on form 172 with each monthly report any additional corrections to be made.

The three divisions of the form are self-explanatory.

USED BY: Local registrar and/or clerk, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: Form 172 is to be completed by the local registrar or clerk each month and transmitted with the original certificates of birth, death and stillbirth. If there have been no changes the form should be signed, "No Change" entered on the face, and the form returned with the monthly report.

COMMENT: It is suggested that the local registrar keep the form available for entering additions, corrections, and removals as the information is received from various sources.

Pages 173-189 missing

MONTHLY REPORT TO VITAL STATISTICS - FORM 190
SIZE 5½" x 8"

_____ COUNTY				
MONTHLY REPORT TO VITAL STATISTICS				
FOR MONTH OF _____ 19____				
THIS REPORT SHOULD REACH DIV. OF V. S., NASHVILLE, ON OR BEFORE THE 10TH OF THE MONTH				
VITAL RECORDS				MISCELLANEOUS
URBAN:	LIST ALPHABETICALLY INCORPORATED TOWNS OF 2500 OR MORE	BIRTHS	DEATHS	STILL- BIRTHS
				CASKET DEALERS REPORTS (130)
				DISINTERMENT PERMITS (127)
				INSTITUTION REPORTS (104-124)
				VIOLATION REPORTS (125-105)
				REGISTER ADDITIONS-CORRECTIONS-REMOVALS (172)
				(RE: PHYSICIANS, OSTEOPATHS, CHIROPRACTORS, MID- WIVES & UNDERTAKERS)
RURAL:				
TOTAL				TOTAL
DATE REPORT MAILED _____				
_____ LOCAL REGISTRAR				
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 190				

PURPOSE: To provide a summary report card for use of registrars in forwarding certificates of birth, death, and stillbirth and certain miscellaneous reports collected during the previous month.

EXPLANATION AND DEFINITIONS:

Urban: The area of a county included in incorporated cities of 2500 or more population.

Rural: The area of a county not included in incorporated cities of 2500 or more population.

USED BY: Local registrar and/or clerk, Division of Vital Statistics.

OFFICE MECHANICS AND FILING: Monthly report card is made by local registrar to accompany original certificates (births, deaths and stillbirths) and forms forwarded to the Division of Vital Statistics. Certificates withheld for clearing on local level should not be included in the report. The card is filed in the Division of Vital Statistics and used in checking registrar's accounts for payment.

COMMENT: All certificates must be dated and signed by the local registrar, and the proper registration district numbers inserted.

For details, see Vital Statistics Registration Manual.

Pages 191-198 missing

VITAL STATISTICS TABLES FOR COUNTY HEALTH DEPARTMENT
FORM 199

SHEET 1

VITAL STATISTICS TABLES

FOR

_____ COUNTY HEALTH DEPARTMENT

- I. SUMMARY VITAL STATISTICS BY COLOR.
- II. NUMBER AND PERCENTAGE OF LIVE BIRTHS AND STILLBIRTHS BY ATTENDANT, BY COLOR.
- III. DEATHS BY SPECIFIC CAUSES WITH RATES PER 100,000 POPULATION AND DEATHS BY SPECIFIC CAUSES BY AGE AT DEATH.
- IV. MONTHLY REPORTS OF BIRTHS, STILLBIRTHS, AND DEATHS FROM SPECIFIC CAUSES.
- V. INFANT DEATHS BY CAUSES WITH RATES PER 1,000 LIVE BIRTHS AND INFANT DEATHS BY CAUSE AND AGE AT DEATH.
- VI. MATERNAL DEATHS BY SPECIFIC CAUSES BY ATTENDANT AT DELIVERY.

SHEET 2

TABLE I

SUMMARY VITAL STATISTICS, BY COLOR, _____ COUNTY, 19 _____

	TOTAL NUMBER RATE	WHITE NUMBER RATE	COLORED NUMBER RATE
ESTIMATED POPULATION, JULY 1, 19			
LIVE BIRTHS*			
DEATHS*			
STILLBIRTHS#			
NEONATAL DEATHS#			
INFANT DEATHS#			
PUERPERAL DEATHS#			

*RATE PER 1,000 POPULATION

#RATE PER 1,000 LIVE BIRTHS

TABLE II

NUMBER AND PERCENTAGE OF LIVE BIRTHS AND STILLBIRTHS ACCORDING
TO ATTENDANT, BY COLOR, _____ COUNTY, 19 _____

ATTENDANT	TOTAL NUMBER PER CENT	WHITE NUMBER PER CENT	COLORED NUMBER PER CENT
LIVE BIRTHS, TOTAL			
PHYSICIAN, HOSPITAL			
PHYSICIAN, HOME			
MIDWIFE			
OTHERS OR UNSPECIFIED			
STILLBIRTHS, TOTAL			
PHYSICIAN, HOSPITAL			
PHYSICIAN, HOME			
MIDWIFE			
OTHERS OR UNSPECIFIED			

SHEET 4

TABLE III

DEATHS FROM SPECIFIC CAUSES WITH RATES PER 100,000 POPULATION AND DEATHS FROM CERTAIN SPECIFIC CAUSES BY AGE AT DEATH

(CONTINUED)

DEATHS BY CAUSES*	TOTAL		AGE AT DEATH IN YEARS									
	NUMBER	RATE	UNDER 5	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65 & OVER	UNK.
DIABETES MELLITUS (61)												
PELLAGRA (69)												
CEREBRAL HEMORRHAGE, EMBOLISM, ETC. (83)			X	X	X	X	X	X	X	X	X	X
DISEASES OF THE HEART (90-95)			X	X	X	X	X	X	X	X	X	X
BRONCHOPNEUMONIA (107)												
PNEUMONIA, LOBAR AND UNSPECIFIED (108, 109)												
DIARRHEA AND ENTERITIS (UNDER TWO YEARS) (119)				X	X	X	X	X	X	X	X	X
DIARRHEA AND ENTERITIS (2 YEARS AND OVER) (120)			X									
APPENDICITIS (121)			X	X	X	X	X	X	X	X	X	X
NEPHRITIS (130-132)			X	X	X	X	X	X	X	X	X	X
DISEASES OF PREGNANCY AND CHILDBIRTH (140-150)			X	X	X	X	X	X	X	X	X	X
CONGENITAL MALFORMATIONS AND DISEASES OF EARLY INFANCY (157-161)			X	X	X	X	X	X	X	X	X	X
SUICIDE (163, 164)			X	X	X	X	X	X	X	X	X	X
HOMICIDE (165-168)			X	X	X	X	X	X	X	X	X	X
ACCIDENTAL DEATHS, TOTAL (169-195)												
MOTOR VEHICLE (170)												
ALL OTHER SPECIFIED CAUSES			X	X	X	X	X	X	X	X	X	X
ILL DEFINED & UNKNOWN CAUSES (199-200)			X	X	X	X	X	X	X	X	X	X

*NUMBERS FOLLOWING CAUSES OF DEATH ARE THOSE OF THE INTERNATIONAL LIST, FIFTH REVISION, 1939

SHEET 5

TABLE IV

MONTHLY REPORTS OF BIRTHS, STILLBIRTHS, INFANT DEATHS, AND DEATHS FROM CERTAIN SPECIFIC CAUSES

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
LIVE BIRTHS													
STILLBIRTHS													
INFANT DEATHS													
DEATHS (TOTAL)													
DEATHS BY CAUSES*													
TYPHOID AND PARATYPHOID FEVERS (1,2)													
MENINGOCOCCUS MENINGITIS (6)													
SCARLET FEVER (8)													
WHOOPING COUGH (9)													
DIPHTHERIA (10)													
TUBERCULOSIS, ALL FORMS (13-22)													
DYSENTERY (27)													
MALARIA (28)													
SYPHILIS (30)													
INFLUENZA (33)													
SMALLPOX (34)													
MEASLES (35)													
ACUTE POLIOMYELITIS (36)													
ACUTE INFECTIOUS ENCEPHALITIS (37)													
TYPHUS FEVER (39 a, b)													
ROCKY MOUNTAIN SPOTTED FEVER (39)													
BRONCHOPNEUMONIA (107)													
PNEUMONIA, LOBAR AND UNSPECIFIED (108, 109)													
DIARRHEA AND ENTERITIS, (UNDER 2 YRS.) (119)													
DIARRHEA AND ENTERITIS, (2 YRS. AND OVER) (120)													
DISEASES OF PREGNANCY AND CHILDBIRTH (140, 150)													
ALL OTHER SPECIFIED CAUSES													
ILL-DEFINED AND UNKNOWN CAUSES (199-200)													

*NUMBERS FOLLOWING CAUSES OF DEATH ARE THOSE OF THE INTERNATIONAL LIST, FIFTH REVISION, 1939

SHEET 6

TABLE V

INFANT DEATHS BY CAUSES WITH RATES PER 1,000 LIVE BIRTHS
AND INFANT DEATHS BY CAUSES AND AGE AT DEATH, _____ COUNTY, 19 ____

DEATHS BY CAUSES*	TOTAL		AGE AT DEATH		
	NUMBER	RATE	UNDER 1 DAY	1 DAY TO 1 MONTH	1 MONTH TO 1 YR.
TOTAL					
INFECTIOUS DISEASES (1-44, EXCLUDING 13, 27, 33)					
RESPIRATORY DISEASES (104-114, 13, 33)					
GASTRO-INTESTINAL DISEASES (27, 118, 119)					
MALFORMATIONS AND EARLY INFANCY (157-161)					
CONGENITAL MALFORMATIONS (157)					
PREMATURE BIRTH (159)					
INJURY AT BIRTH (160)					
OTHER (158, 161)					
ALL OTHER DEFINED CAUSES					
ILL-DEFINED AND UNKNOWN CAUSES (199-200)					

*NUMBERS FOLLOWING CAUSES OF DEATH ARE THOSE OF THE INTERNATIONAL LIST, FIFTH REVISION, 1939

TABLE VI

MATERNAL DEATHS BY SPECIFIC CAUSES, BY ATTENDANT AT DELIVERY
_____ COUNTY, 19 ____

DEATHS BY CAUSES*	TOTAL		ATTENDANT AT DELIVERY			
	NO.	RATE	PHYSICIAN HOSPITAL	PHYSICIAN HOME	MIDWIFE	OTHER OR UNSPECIFIED
TOTAL						
PUERPERAL HEMORRHAGE (143, 146)						
PUERPERAL SEPTICEMIA (140, 142a, 147)						
TOXEMIAS OF PREGNANCY (144, 148)						
(141, 142b, OTHER PUERPERAL CAUSES 145, 149, 150)						

*NUMBERS FOLLOWING CAUSES OF DEATH ARE THOSE OF THE INTERNATIONAL LIST, FIFTH REVISION, 1939

VITAL STATISTICS TABLES FOR COUNTY HEALTH DEPARTMENT - FORM 199

PURPOSE: To furnish information pertaining to births, deaths and stillbirths.

EXPLANATION AND DEFINITIONS:

Table IV, if filled in monthly, is made up from summary cards and shows recorded data for year.

Tables I, II, III and V are filled in yearly from summary cards for current year, and show resident data.

Recorded data: According to the place of birth, death or stillbirth.

Resident data: According to residence of mother of birth or stillbirth, and according to residence of the deceased, with exceptions of infectious diseases, accidents and homicides. In cases of infectious diseases the death is allocated to the place, if known, where the disease was contracted. Deaths from accidents and homicides are charged to the place of occurrence.

See definitions in Vital Statistics Bulletin.

USED BY: Health department personnel for planning local programs.

OFFICE MECHANICS AND FILING: Made by the clerk and filed in Vital Statistics Tables Folder.

11-3-47

FRONT

DEAR DOCTOR:

Please list on the return card the cases of reportable diseases which you have attended for the first time during the past week, detach and mail immediately. No postage is required.

This card is for your weekly report of ALL notifiable diseases. Certain diseases requiring immediate control measures must also be reported at once to the responsible local health officer. (See list of these diseases on the other side of this card.)

Please return this postal card even if you have nothing to report, in order that we may know you have received the card.

Penalty envelopes in which your report cards can be enclosed will be furnished on request.

R. H. HUTCHESON, M. D.,
Collaborating Epidemiologist, P. H. S.

Prevention and control of disease from the public health point of view require prompt notification of when and where cases of disease are occurring.

16-8962-2 GPO

NOTIFIABLE DISEASES

Diseases to be reported by telephone to local health officer and on weekly written report card

Anthrax. Kerato-conjunctivitis (infection). Relapsing fever. Rocky Mountain spotted fever. Sandfly fever. Scarlet fever. Schistosomiasis. Septic sore throat. Smallpox. Tularemia. Typhus fever. Typhoid fever. Uduilant fever. Yellow fever.

FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE
OFFICIAL BUSINESS

PENALTY FOR PRIVATE USE TO AVOID
PAYMENT OF POSTAGE, \$300
(GPO)

ASSISTANT
COLLABORATING EPIDEMIOLOGIST
Public Health Service

Tennessee

WEEKLY WRITTEN REPORT

Actinomycosis. Histoplasmosis. Pericardial septemia. Hookworm disease. Rabies in man. Rheumatic fever. Tetanus. Trachoma. Trichinosis. Tuberculosis. Yaws.

Use special forms for reporting venereal diseases and malignancies (cancer).

16-8962a-4

BACK

OFFICIAL BUSINESS

NASHVILLE 3, TENN.
COLLABORATING EPIDEMIOLOGIST
PUBLIC HEALTH SERVICE
FEDERAL SECURITY AGENCY

PENALTY FOR PRIVATE USE TO AVOID
PAYMENT OF POSTAGE, \$300
(GPO)

NOTIFIABLE DISEASE REPORT—EXCLUDING VENEREAL DISEASES

Disease	Name	Address, P. O., Street	County or City	Color	Sex	Age

Please list above all your new cases of notifiable diseases for the week ending

Please mail this card promptly even if you have no cases to report.

WEEKLY MORBIDITY CARD - FORM 16-8962 (FORM 200)

PURPOSE: To obtain weekly reports of all reportable diseases occurring in the practice of each physician.

EXPLANATION AND DEFINITIONS:

Disease: Give type and stage of disease for tuberculosis.

Other items are self-explanatory.

USED BY: Clerk acting in capacity of Assistant Collaborating Epidemiologist.

OFFICE MECHANICS AND FILING: On a regular day each week one of those cards dated and numbered is sent to each physician in the health officer's jurisdiction. On return, cards are cross checked to ensure complete and comparable record in office file (Form 206) and in batch of cards sent to the State Department of Health each Monday. An office card is made for each case first reported on physician's report card, and, where telephonic or verbal report has been made, but is not recorded by physician on his weekly card. A physician's report card signed by health officer is used for completing data to be forwarded to the State Health Department. Cases reported for first time by death certificates should be reported on health officer's weekly card, being marked with an asterisk, a note at bottom to indicate reported by death certificate.

COMMENT: While the health department should make every effort to stimulate physicians to notify promptly on reportable diseases, it is not the function of the department to make weekly inquiries of the physician as to whether or not he had cases of such diseases in his practice. More rapid progress may appear to be made when the health department assumes the responsibility of telephoning to make these inquiries and the per cent of physicians "reporting" will appear to be high under this arrangement, but it is not a sound procedure. It changes the whole relationship of health department and private physician in communicable disease reporting.

The Central Office should be notified when new physicians locate in the county or when a physician dies, moves or retires.

All code numbers for reporting physicians must be assigned from the Central Office.

Code numbers for all health officers and assistant health officers are "000." In cases of transfer from one county to another, the code number is always the same.

Reports must be in Central Office promptly to be included in weekly telegraphic report to the United States Public Health Service.

REPORT OF MALIGNANT NEOPLASMS - FORM 201
SIZE 3½" x 5½"

REPORT OF MALIGNANT NEOPLASMS		TENNESSEE DEPARTMENT OF PUBLIC HEALTH IN COOPERATION WITH U. S. PUBLIC HEALTH SERVICE	
NAME OF PATIENT _____		DATE REPORTED _____	
ADDRESS: STREET _____		CITY OR TOWN _____	
COUNTY _____		COLOR _____ SEX _____ AGE _____	
SITE OF LESION _____		BIOPSY: YES _____ NO _____	
TYPE OF MALIGNANCY _____			
METASTASIS _____			
<div style="text-align: right; margin-top: 10px;"> SIGNATURE _____ ADDRESS _____ </div>			

201

PURPOSE: To obtain reporting of cases of malignant neoplasms diagnosed by physicians and hospitals.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Physicians, hospitals, clinics and health department personnel.

OFFICE MECHANICS AND FILING: Booklets of the report cards and envelopes are distributed to the physicians and hospitals by the local health departments. As the physicians and hospitals return the cards, the information is transcribed to Office Report Cards, Form 206 and Form 207, and the report cards are forwarded to the Tennessee Department of Public Health with other morbidity report cards at the end of each week. Death certificates showing malignant neoplasms are checked against reported cases and if the cases have not been reported, cards are made out by the clerk and are forwarded to the Tennessee Department of Public Health. A case reported for first time by death certificate should be marked with an asterisk and a note added at bottom to indicate reported by death certificate.

Pages 202-203 missing

VENEREAL DISEASE CASE REPORT - FORM 204
 SIZE 3½" x 5½"

UNITED STATES PUBLIC HEALTH SERVICE IN COOPERATION WITH TENNESSEE DEPARTMENT OF PUBLIC HEALTH VENEREAL DISEASE CASE REPORT			
Name _____			
Address _____		Date _____	
City _____	County _____	Color _____	Sex _____ Age _____
SYPHILIS			
Primary, with lesions	<input type="checkbox"/>	GONORRHEA { <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> Genital <input type="checkbox"/> Eye <input type="checkbox"/> other <input type="checkbox"/> </div>	<input type="checkbox"/>
Secondary, with lesions	<input type="checkbox"/>		<input type="checkbox"/>
Early latent, without lesions (duration under 4 yrs.)	<input type="checkbox"/>		<input type="checkbox"/>
Late latent, without lesions (duration 4 yrs. and over)	<input type="checkbox"/>		<input type="checkbox"/>
Late, with signs and symptoms	<input type="checkbox"/>	CHANCROID	<input type="checkbox"/>
Congenital	<input type="checkbox"/>	GRANULOMA INGUINALE	<input type="checkbox"/>
Previous Treatment: Yes <input type="checkbox"/> No <input type="checkbox"/>		LYMPHOGRANULOMA VENEREUM	<input type="checkbox"/>
Is Patient Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Laboratory Confirmation of Diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/>			
FORM 204 Signed _____ Address _____		M.D.	

PURPOSE: To furnish private physicians and health officers a form for reporting cases of venereal diseases seen in their clinics and offices which have not been reported previously.

EXPLANATION AND DEFINITIONS: The explanation of the classification of the diseases may be found in the instructions for the Venereal Disease Record, Form 233.

USED BY: Private physician, health officer, nurse, and clerk.

OFFICE MECHANICS AND FILING: After the information appearing on these cards has been recorded on the Office Report Cards, Form 206 and Form 207, these case reports should be sent with the weekly Morbidity Report Cards to the Tennessee Department of Public Health. (All morbidity reports should reach Nashville by Tuesday morning).

This form will be furnished by the local health department to private physicians for their use in reporting cases of venereal diseases to the Tennessee Department of Public Health. Franked envelopes will be furnished when necessary.

Page 205 missing

COMMUNICABLE DISEASE OFFICE REPORT CARD - FORM 206
SIZE 4" x 6"

				DATE _____
PATIENT _____	COLOR _____	SEX _____	AGE OR DATE OF BIRTH _____	NUMBER _____
DISEASE _____		STAGE, ACTIVITY OR SITE _____		
HEAD OF HOUSEHOLD _____				
ADDRESS _____				
PHYSICIAN _____				
REMARKS _____				

TENNESSEE DEPARTMENT OF PUBLIC HEALTH-206				

PURPOSE: To provide for office purposes, a unit file of reportable diseases, and a record of all such diseases, whether or not handled as a communicable disease by the health department.

EXPLANATION AND DEFINITIONS: A space is provided for *Age or Date of Birth*. For reports of reportable diseases, age is given. For the roster of crippled children, date of birth is desirable.

The term *Disease* as used here refers to all reportable diseases, including malignant neoplasms, syphilis and tuberculosis. In addition to disease for tuberculosis, syphilis and malignant neoplasms, data regarding stage, activity or site should be recorded in the space provided.

USED BY: Routinely used by clerk and any member of staff studying or checking reports of reportable diseases.

OFFICE MECHANICS AND FILING: This card is prepared for each reportable disease immediately on receipt of verbal or telephone notification, and at end of week from returned physicians report cards. For all cases reported by telephone and reported on weekly report cards which need investigation or nursing visit, this information is called to the attention of the person responsible for instituting isolation or quarantine, or making visit. These cards are given serial numbers beginning with the first case reported during a year, filed by disease and alphabetically by the patient's name. At the end of the current year, the office report cards are filed with the cards for previous years. A Chronological Card, Form 207, is kept in the file for each disease.

At the end of the year, cards for malignant neoplasms, syphilis, tuberculosis, undulant fever, and rheumatic fever, are filed with cards for these diseases received in previous years. These reports of malignant neoplasms, syphilis, tuberculosis, undulant fever, and rheumatic fever files are divided into two parts: (1) active, and (2) closed.

The files of cases for current year and previous years serve as rosters for malignant neoplasms, syphilis, tuberculosis, undulant fever, and rheumatic fever. Deaths from reportable diseases are checked against the Office Report Card File, and any case reported only by death certificate is marked with an asterisk placed beside the serial number of the case.

For convenience, this card is also used for maintaining a roster of crippled children and of typhoid carriers.

COMMENT: These communicable disease office cards are useful for reference, for checking and for summaries of reports. The communicable disease case records, however, provide the information necessary for proper handling of the case and for studies of cases occurring in an area. The office cards are readily accessible while the case records are kept in family folders.

2-1-49

CHRONOLOGICAL CARD - FORM 207
(COMMUNICABLE DISEASE)
SIZE 4" x 6"

[illegible]

PURPOSE: To provide for summarized chronological record of each of the various reportable diseases.

EXPLANATION AND DEFINITIONS: On top line, enter name of disease which card will summarize, as "diphtheria." Under date is inserted date on which report of case is received. Under number insert serial number of case. First case reported on or after January 1, is case No. 1, the second, case No. 2, etc. Under name is inserted the name of the person reported as having the disease.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: This card is the first one filed under "diphtheria" or "typhoid", etc., in the office communicable disease file. More than one such card may be required for certain diseases. An entry is made on this card before any new office communicable disease card is placed in file. At the end of each month a red line is drawn under the last case entered on this card. Any case reported only by death certificate is marked with an asterisk placed beside the serial number of the case.

COMMENT: Without such a card, the health officer has no way of knowing how many cases have occurred or are occurring and who has the disease. A map, showing location of cases, presents useful supplementary information as to where cases occur.

Pages 208-209 missing

COMMUNICABLE DISEASE RECORD - FORM 210
SIZE 10" X 8"

FRONT

[illegible]

[illegible]

Conclusions as to Source of Infection

RECORD OF HOME VISITS

Worker

Outcome

Remarks:

COMMUNICABLE DISEASE RECORD - FORM 210

PURPOSE: To provide information both for study as to source of disease and for administrative procedures in controlling spread. Used for cases of diphtheria, bacillary dysentery, encephalitis, meningococcus meningitis, paratyphoid fever, poliomyelitis, Rocky Mountain spotted fever, scarlet fever, smallpox, tularemia, typhoid fever, typhus fever, undulant fever, and other communicable diseases necessitating epidemiological studies.

EXPLANATION AND DEFINITIONS:

Household Roster: The name of the case should be placed on the line for Pt. in the household roster. Space is provided for the necessary information for household contacts. If one of these contacts becomes a case, a new record is opened and the secondary case is handled as the original case.

Excreta Disposal: In the case of filth-borne diseases, particular care should be taken in giving complete and accurate information.

Water Supply: Recorded as to source and whether protected or unprotected.

Screens: Recorded as none, partial, complete, and size of mesh present.

Disposal of Patient's Discharges: Recorded as to method of disinfection and disposal.

Food Consumed During Incubation Period: Recorded as kind, place, and source. For milk and milk products it is important to know the dairy producing the milk as well as the retail place of purchase, if any.

Probable Extra-familial Source Contacts: Refers to selected individuals from whom the disease may have been contracted. In an epidemiological investigation certain individuals will stand out as probable sources. No name should be listed here without a definite reason.

Spread Contacts: Refers to persons other than members of the household who have been exposed to the case.

Control Problems: Here are recorded such items as sale of milk, over-crowding, school, probable isolation, etc.

Record of Home Visit: The individual home visits when combined should give a clear epidemiological picture of the source of the case and how the source was found. A history of the case including symptoms, signs, etc., should be recorded here. In cases of diphtheria, the amount of the antitoxin received, the dates received, and the type of general care being received by the patient should be recorded.

USED BY: Health officer, nurse, sanitation officer, and clerk.

OFFICE MECHANICS AND FILING: This record is opened by the person who makes the first contact with the diagnosed or suspected case. The record is indexed by the clerk and filed in the family folder. Under laboratory findings, the spaces provided for *Date* and *Type* are filled in by the field worker at the time the specimen is collected for mailing and *Results* are recorded by the clerk when the information is received from the laboratory. *Release Data and Conclusions as to Source of Infection* are recorded by the health officer at the time the case is closed. When the case is released from communicable disease supervision, the record is closed, a summary is made on the inside of the family folder, a note is made on the health record, and the closed communicable disease record is filed in closed file.

COMMENT: All probable source contacts should be listed in the proper spaces provided. Feces and urine specimens should be obtained on all source contacts as listed for paratyphoid and typhoid fever cases. For contacts to paratyphoid and typhoid cases, feces and urine specimens should be obtained from all adult familial contacts and all childhood familial contacts with a history of a suspicious illness.

Nose and throat specimens should be obtained for culture only for diagnostic purposes in diphtheria. Release cultures on cases and contacts of diphtheria are not required and should not be done except under special circumstances. Diphtheria cases are released from isolation by death, or 14 days from onset provided abnormal discharges have ceased.

Typhoid cases are released from supervision only after two negative stool and urine cultures, death, or removed. In the event of removal, the new address is reported to the health officer in the community to which the case moved.

11-3-47

Pages 211-213 missing

TYPHOID CARRIER RECORD - FORM 214
SIZE 10" x 8"

FRONT

TYPHOID CARRIER RECORD

Date Found	Date of Disease	Investigator		Carrier No.
Name	Color	Sex	Age	M S D W
Address		Directions		Occupation
Address		Directions		Occupation
Address		Directions		Occupation
Address		Directions		Occupation
Economic Status				
Symptoms referable to gall bladder				

[illegible]

HOUSEHOLD CONTACTS

[illegible]

EXTRA-FAMILIAL CONTACTS

[illegible]

BACK

TYPHOID CARRIER RECORD - FORM 214

PURPOSE: To provide information both for study of typhoid carriers and for administrative procedures in the control of the spread of typhoid fever. When properly used, all necessary information about the carrier and his associates will be recorded.

EXPLANATION AND DEFINITIONS:

Extra-familial Contacts: By this term is meant close contacts and includes relatives of the carrier not living in the household and such friends or neighbors with whom the carrier is associated.

Control Problems: Refers to food handling, sanitary environment, personal hygiene, etc.

Record of Home Visits: Should contain such information as how carrier was found, cooperation of the carrier, educational instructions given, etc.

USED BY: Health officer, nurse, clerk, and sanitation officer.

OFFICE MECHANICS AND FILING: This record is opened by the health officer when a carrier is found or when a case continues to carry the micro-organisms for at least one year after he is free of fever. The record is kept in an active file from year to year, and is closed only when a carrier dies or moves from the county. When a typhoid carrier record is opened by a health officer, a copy of the record along with a copy of the Typhoid Carrier Acknowledgment is sent to the Director of the Division of Preventable Diseases.

If a carrier moves to an organized county in the State, a letter giving such information as necessary is written to the health officer of the county into which the carrier has moved and sent to him along with a copy of his record. A copy of this letter should be sent to the Director of the Division of Preventable Diseases. The signature of that carrier should be obtained on a new Typhoid Carrier Acknowledgment in the new county. If a carrier moves to an unorganized county or out of the State, then a letter of information and a copy of his record is sent to the Director of the Division of Preventable Diseases. A Typhoid Carrier Roster is kept. This roster is composed of all cards made for carriers in previous years. These cards are filed in two sections - (1) active (2) closed, (cards are closed only for carriers who have moved out of the county or who have died).

COMMENT: By properly using this record a health officer will have at hand at all times a picture of the circumstances surrounding the carrier. By referring to the record, he may determine which contacts have been inoculated and see that those who have not been inoculated receive the immunization. Such contacts should receive typhoid vaccine yearly. Except under special circumstances there is no reason to require feces and urine specimens after obtaining two positive specimens one year after recovery. A visit by the health officer or nurse should be made every six months to see that precautions are taken to prevent spread of the disease. The sanitation officer should visit the carrier regularly to see that proper facilities for excreta disposal are provided and kept in proper condition.

TYPHOID CARRIER ACKNOWLEDGMENT - FORM 215
SIZE 11" x 8½"

STATE OF TENNESSEE
DEPARTMENT OF PUBLIC HEALTH
Nashville

TYPHOID CARRIER ACKNOWLEDGMENT

Acknowledgment Concerning _____
(Name)

(Address)

I hereby acknowledge that I have been informed by Dr. _____
_____ County Health Officer, that I am a chronic typhoid carrier and that in order
to prevent the spread of the disease to others, it will be necessary for me to conform to the following
recommendations:

That I should not prepare or handle any food to be eaten by persons other than mem-
bers of my own family;

That all members of my household should receive the typhoid vaccine every two years;

That I should have provided at my home a sanitary method of excreta disposal and
should dispose of my excreta only by such method;

That I should wash my hands thoroughly with soap and water after each visit to the
toilet;

That I should not in any way assist with milking or in the handling of milk or milk uten-
sils except that milk which is to be used by my own household;

That before changing my occupation or address, I should notify the health officer of
such anticipated change of occupation or address.

(Signature of Carrier)

(Witness)

(Date)

TYPHOID CARRIER ACKNOWLEDGMENT - FORM 215

PURPOSE: This record is to be signed by typhoid carriers in accordance with *Regulations Governing Control of Communicable Diseases in Tennessee*.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: The record should be made in triplicate, one copy to be given to the carrier, one to be sent to the Director of the Division of Preventable Diseases, and the other to be filed in the local office. If the carrier moves to another county with full-time health department, notice should be sent to the health officer of that county and to the Director of the Division of Preventable Diseases. The signature of that carrier on a new Typhoid Carrier Acknowledgment should be obtained in the county into which the carrier has moved.

11-3-47

FORMAL NOTICE OF ISOLATION OR QUARANTINE - FORM 216
SIZE 5" x 8"

FRONT

City of _____
 County of _____
 State of Tennessee _____

FORMAL NOTICE OF ISOLATION OR QUARANTINE

To: M _____

and To Whom It May Concern

These premises are under isolation or quarantine because of _____

In addition to the *Health Authorities* and the *Attending Physician*, the following are hereby permitted to enter and leave the premises for the purposes stated:

_____ for the purpose of _____
 _____ for the purpose of _____
 _____ for the purpose of _____

The contacts listed above agree not to visit the room where patient is isolated, to keep away from children and from public gatherings, and otherwise to carry out necessary precautions. *This permission becomes null and void upon breach of agreement by said contacts.*

The following children may enter school only on presentation of isolation or quarantine release.

_____	Age _____	Sex _____	Attending _____	School _____
_____	Age _____	Sex _____	Attending _____	School _____
_____	Age _____	Sex _____	Attending _____	School _____
_____	Age _____	Sex _____	Attending _____	School _____

Restrictions on the purchase or sale of milk by members of this household are set forth on the back of this form.

Health Officer _____

Date _____

By _____

(Deputy Health Officer)

Isolation or quarantine in this case will extend at least until _____. It may be longer.

The state law attaches severe penalty to violation of quarantine.

(Over)

BACK

QUARANTINE

No person in this house is allowed to engage in the handling of milk or other foodstuffs, nor is milk or any foodstuffs permitted to be sold or removed from these premises during quarantine.

Children of the family are not permitted to leave the yard, nor to come into contact with other children.

No visitors are permitted.

Milk bottles or other receptacles must not be returned to dairy until quarantine is over. They should then be boiled before return. If you receive milk, place a receptacle in convenient place for dairyman, who will empty milk from his receptacle to yours. Groceries and supplies may be left on steps or porch by deliveryman.

Laws and regulations for quarantine are made by the state, and are for the protection of the public. Do not request your family physician or the health officer to shorten the quarantine: they have no more authority to break the law than you have.

Quarantine is not concerned with whether or not the patient is sick enough to need a doctor. It is a question of whether or not he is a source of danger to others. It is because of danger to others that quarantine is carried out.

FORMAL NOTICE OF ISOLATION OR QUARANTINE - FORM 216

PURPOSE: To serve as formal written notification of isolation or quarantine to the head of the house, school authorities, dairymen, and other individuals or firms concerned, and to save the physician and health department many pleas for special consideration: to provide reasonable freedom of workers where arrangement of home and intelligence and honesty of family justify provisional quarantine leave. Carbon copies may be used.

EXPLANATION AND DEFINITIONS: This form is largely self-explanatory. The last blank space on the face of the card is filled in in accordance with the Regulations Governing Communicable Diseases in Tennessee. The attention of the head of the house is directed to the information on quarantine which is printed on the back of the form.

USED BY: Health officer or his duly authorized deputy. This does not include private physician.

OFFICE MECHANICS AND FILING: The person instituting isolation or quarantine is responsible for getting information concerning school children, dairymen, and other individuals or firms to be notified to clerk who mails notices. If office is closed, person instituting isolation or quarantine mails notice to school authorities, or notice may be delivered personally. Verbal notification must not be substituted for written.

COMMENT: This form provides isolation or quarantine procedure that is necessary and is of value in the event that a case has to be carried to Court.

The laws of the State require that school authorities be notified of communicable disease (see Regulations Governing Control of Communicable Disease). It is more satisfactory to effect an arrangement whereby the principal of the school concerned is notified as the agent for the board of education than to notify the superintendent of public instruction.

ISOLATION OR QUARANTINE RELEASE - FORM 217
SIZE 3" x 5"

ISOLATION OR QUARANTINE RELEASE

The above named, recently under isolation or quarantine because of _____ is hereby given full liberty and permission to resume ordinary occupation.

All restrictions concerning visitors and the purchase or sale of milk imposed by isolation or quarantine have been removed.

Date _____ Health Officer _____

Tennessee Department of Public Health No. 217

PURPOSE: To provide regular procedure for certification that isolation or quarantine restrictions have been removed. Necessary in release of school children, food handlers, and those returning to an organized industrial plant.

EXPLANATION AND DEFINITIONS: This form is largely self-explanatory.

USED BY: Health officer or his duly authorized deputy. This does not include private physicians.

OFFICE MECHANICS AND FILING: Copies must be furnished each individual under isolation or quarantine who needs to return to school or to his occupation.

COMMENT: This form is used to notify members of household and school authorities that such isolation or quarantine has been terminated.

Pages 218-219 missing

IMMUNIZATIONS - FORMS 220, 221, 222, 223
SIZE 3" x 5"

TYPHOID IMMUNIZATION, FORM 220

Name _____		Age _____	
Last	First		
Address _____	District _____	Color _____	Sex _____
School _____		Parent's Name _____	
TYPHOID IMMUNIZATION			
DATE		REMARKS	
1 _____		_____	
2 _____		_____	
3 _____		_____	
Tennessee Department Public Health No. 220			

DIPHThERIA IMMUNIZATION, FORM 221

Name _____		Color _____		Sex _____	
Last	First				
Community _____		District _____			
School _____		Parent's Name _____			
DIPHThERIA IMMUNIZATION					
IMMUNIZING AGENT			SCHICK TEST		
DATE	AGE	AGENT AND AMOUNT	DATE	AGE	RESULT
Code: T. A. T.—Toxin-antitoxin A. T. —Alum Toxoid P. T. —Plain Toxoid					
Tennessee Department of Public Health No. 221					

220)
221)-1
222)
223)

SMALLPOX IMMUNIZATION, FORM 222

Name		Age	
Last	First		
Address	District	Color	Sex
School		Parent's Name	
SMALLPOX IMMUNIZATION			
DATE	RESULT	REMARKS	
DATE OLD SCAR		Tennessee Department Public Health No. 222	

WHOOPING COUGH IMMUNIZATION, FORM 223

Name		Date of Birth	
LAST	FIRST		
Community	District	Color	Sex
School		Parent's Name	
WHOOPING COUGH IMMUNIZATION			
DATE	AGENT	AMOUNT	REMARKS
TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 223			

PURPOSE: To provide for record of inoculations given.

EXPLANATION AND DEFINITIONS:

District: Refers to Civil District.

Parent's Name: This is for identification. For children give given names of both parents.

USED BY: Health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: This card is filled out at the time the inoculation is given, and the date of inoculation is entered. Where the inoculation is given in series, the same card is used for the recordings of subsequent inoculations with dates. Cards for whooping cough and typhoid, if given in series, are neither counted nor filed until series are finished. The inoculation is recorded on the "Health Record" and the inoculation card is filed.

In order to keep the inoculation file as small as possible, cards for one individual and one type of inoculation are combined by entering dates on one card and destroying the other card. EXCEPTION: Only current typhoid immunization card on individual is kept. When the typhoid immunization card for an individual is filed and the clerk finds a card in the general immunization card file for this individual showing previous typhoid inoculations, the old card should be destroyed without transferring the information to the current card.

When an inoculation series is begun and the second or third dose is not taken within a reasonable period of the preceding dose, it is counted incomplete. The record of incomplete inoculations is entered on the "Health Record", the number of inoculations entered on "Summary Of Certain Tests and Inoculations", Form 11, and cards filed

Pages 224-227 missing

NOTIFICATION POST CARD - FORM 228
 (WHOOPIING COUGH AND DIPHTHERIA)
 SIZE 3¼" x 5½"

	194
Dear Mrs. _____:	
It is now time for _____ to have _____ immunization.	
Please take this card to your family physician or bring it to the Health Department at _____ on _____ from _____: _____ M to _____: _____ M.	
Please bring this card with you.	
Health Department	
TENNESSEE DEPARTMENT OF PUBLIC HEALTH 228	

PURPOSE: To notify parents that it is time for these preventive treatments to be given. The use of this card should be of value in increasing the number of children protected against these diseases.

EXPLANATION AND DEFINITION: The card is so devised that the mother may know that it is time for her to take her baby to the family physician or to a health department clinic.

OFFICE MECHANICS: Two cards are to be prepared by the clerk at the time that the birth certificate of a child resident of the area is received. One card is to be filled in for whooping cough immunization, and addressed. A stamp is to be added and the card mailed when the child is three months of age.

The second card for diphtheria immunization is to be prepared in the same way and is to be mailed when the child is nine months of age.

For the clerk's convenience these cards may be arranged in a weekly mailing file. All infant death certificates should be checked against this file routinely and cards removed.

SUMMARY OF CERTAIN TESTS AND INOCULATIONS - FORM 229

SIZE 11" x 8½"

SUMMARY OF CERTAIN TESTS AND INOCULATIONS

MONTH _____ YEAR _____

	D O S E	Color	Under 1 Year	1 Year	2 Years	3 Years	4 Years	5 Years	6 Years and Over	TOTAL							
TYPHOID VACCINE	Incomplete Series One Dose	W															
		C															
	Incomplete Series Two Doses	W															
		C															
	Completed Series Three Doses	W															
		C															
	One Dose Completed	W															
		C															
SMALLPOX VACCINE	Vaccination	W															
		C															
	Re-Vaccination	W															
		C															
TUBERCULIN TESTS	0.01 Mg.	W															
		C															
	1.0 Mg.	W															
		C															
TOXOID ALUM PRECIPITATED	One Dose Completed	W															
		C															
	Second Dose	W															
		C															
			Under 1 Mo.	1 Mo.	2 Mos.	3 Mos.	4 Mos.	5 Mos.	6 Mos.	7 Mos.	8 Mos.	9 Mos.	10 Mos.	11 Mos.	1 Yr.	2 Yrs. and Over	TOTAL
WHOOPIING COUGH VACCINE	Incomplete Series One Dose	W															
		C															
	Incomplete Series Two Doses	W															
		C															
	Completed Series Three Doses	W															
		C															
	Other Dose	W															
		C															

SUMMARY OF CERTAIN TESTS AND INOCULATIONS - FORM 229

PURPOSE: To provide a summary record of tests and inoculations given by the local health department, according to the type of inoculation, by race and age.

EXPLANATION AND DEFINITIONS:

Typhoid Vaccine: A completed series of typhoid inoculations consists of three doses of typhoid vaccine at weekly intervals. The cards prepared for typhoid immunization (220) should be held until sufficient time has elapsed for completion of the series. After this interval the cards should be used for preparation of the summary of tests and inoculations. The cards would then be separated according to the results: 1) Incomplete series, one dose, 2) Incomplete series, two doses, 3) Completed series, three doses, and by age and race.

In the fourth section under typhoid vaccine are spaces for recording the number of persons, by age and color, who have received a "booster" dose for re-immunization. These are persons who had previously received a completed series (three-dose series).

Smallpox Vaccine: Only original vaccination should be included in the space provided for "vaccination." Other vaccinations for smallpox should be classed re-vaccinations.

Tuberculin Tests: The number of persons given 0.01 mg. of tuberculin is to be given in the space provided. The number with a second dose (1.0 mg.) is given in the space for 1.0 mg.

Toxoid - Alum Precipitated: Since one dose of alum precipitated toxoid is considered a complete immunization for purposes of tabulation, the number receiving one dose completed is the number inoculated for the first time. Under second dose is given the number receiving a second dose one month after the first dose and those receiving a "booster" dose at the time the child enters school.

Whooping Cough Vaccine: A completed series of whooping cough inoculations consists of three doses of whooping cough vaccine at three-week intervals. The cards prepared for whooping cough immunizations (223) should be held until sufficient time has elapsed for completion of the series. After this interval, the cards should then be separated according to the result, 1) Incomplete series, one dose, 2) Incomplete series, two doses, 3) Completed series, three doses, and by age and race.

In the fourth section under whooping cough vaccine are spaces for recording the number of persons by age and race who have received an additional dose or doses in a series of more than three doses or who have had a "booster" dose of whooping cough vaccine at nine or ten months of age.

USED BY: Health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: When the inoculation cards are ready to be filed, the clerk counts the inoculations by type, age, and color, and records the number on this form in the proper space. One of these forms is used each time a group of cards is filed. A careful check is made to see that the numbers by age groups add to the total and that the numbers by races add to the total. These groups are then combined into a monthly summary which is submitted to the health officer for his use. From such a record the health officer may know the percentage of incomplete inoculations, and the age and color of the individuals inoculated.

Pages 230-232 missing

EPIDEMIOLOGICAL REPORT (WHITE) - BACK

[illegible]

EPIDEMIOLOGICAL REPORT (PINK)

EPIDEMIOLOGICAL REPORT					
SUSPECT					
NAME	COLOR	SEX	AGE	DATE OF REPORT	
ADDRESS	CITY	COUNTY	STATE	TEL. NO.	
WEIGHT	HEIGHT	HAIR	EYES	IDENTIFYING MARKS	
PLACE OF EXPOSURE	DATE OF EXPOSURE		PLACE OF EMPLOYMENT		
REASON FOR INVESTIGATION: CONTACT: () MARITAL, () FRIEND, () PICK-UP, () PROSTITUTE, () OTHER OTHER: () MILITARY, () PREMARITAL, () FOOD HANDLER, () INDUSTRY, () OTHER					
INFORMANT					
NAME OR CLINIC NO.	DISEASE		STAGE	DURATION	
CLINIC	INTERVIEWER				
RESULT OF INVESTIGATION					
NOT FOUND: REASON					
FOUND: 1. EXAMINED NOT INFECTED					
2. PREVIOUSLY UNDER TREATMENT					
3. INFECTED, NEW PATIENT	DISEASE		STAGE		
HEALTH DEPARTMENT	INVESTIGATOR			DATE	
TENNESSEE DEPARTMENT PUBLIC HEALTH					

EPIDEMIOLOGICAL REPORT (YELLOW)

EPIDEMIOLOGICAL REPORT				
SUSPECT				
NAME	COLOR	SEX	AGE	DATE OF REPORT
<hr/>				
ADDRESS	CITY	COUNTY	STATE	TEL. NO.
<hr/>				
WEIGHT	HEIGHT	HAIR	EYES	IDENTIFYING MARKS
<hr/>				
PLACE OF EXPOSURE	DATE OF EXPOSURE	PLACE OF EMPLOYMENT		
<hr/>				
REASON FOR INVESTIGATION:				
CONTACT: () MARITAL, () FRIEND, () PICK-UP, () PROSTITUTE, () OTHER				
OTHER: () MILITARY, () PREMARITAL, () FOOD HANDLER, () INDUSTRY, () OTHER				
<hr/>				
INFORMANT				
NAME OR CLINIC NO.	DISEASE	STAGE	DURATION	
<hr/>				
CLINIC	INTERVIEWER			
<hr/>				
RESULT OF INVESTIGATION				
NOT FOUND: REASON				
<hr/>				
FOUND: 1. EXAMINED NOT INFECTED				
2. PREVIOUSLY UNDER TREATMENT				
3. INFECTED, NEW PATIENT				
<hr/>				
HEALTH DEPARTMENT	INVESTIGATOR	DATE		
<hr/>				
TENNESSEE DEPARTMENT PUBLIC HEALTH				

EPIDEMIOLOGICAL REPORT (YELLOW CARD) - FRONT

EPIDEMIOLOGICAL REPORT				
SUSPECT				
NAME	COLOR	SEX	AGE	DATE OF REPORT
<hr/>				
ADDRESS	CITY	COUNTY	STATE	TEL. NO.
<hr/>				
WEIGHT	HEIGHT	HAIR	EYES	IDENTIFYING MARKS
<hr/>				
PLACE OF EXPOSURE	DATE OF EXPOSURE	PLACE OF EMPLOYMENT		
<hr/>				
REASON FOR INVESTIGATION:				
CONTACT: () MARITAL, () FRIEND, () PICK-UP, () PROSTITUTE, () OTHER				
OTHER: () MILITARY, () PREMARITAL, () FOOD HANDLER, () INDUSTRY, () OTHER				
<hr/>				
INFORMANT				
NAME OR CLINIC NO.	DISEASE	STAGE	DURATION	
<hr/>				
CLINIC	INTERVIEWER			
<hr/>				
RESULT OF INVESTIGATION				
NOT FOUND: REASON				
<hr/>				
FOUND: 1. EXAMINED NOT INFECTED				
2. PREVIOUSLY UNDER TREATMENT				
3. INFECTED, NEW PATIENT				
<hr/>				
HEALTH DEPARTMENT	INVESTIGATOR	DATE		
<hr/>				
TENNESSEE DEPARTMENT PUBLIC HEALTH				

VENEREAL DISEASE RECORD - BACK

VENEREAL DISEASE RECORD										NO. _____		
NAME			COLOR		SEX		DATE OF BIRTH			MARITAL STATUS		
ADDRESS				CITY OR COUNTY			DATE ADMITTED					
PREVIOUS TREATMENT OF SYPHILIS: WHERE							DATES		(ARB. DIS. PEN. AMT.)			
DIAGNOSIS			DATE REPORTED		DATE SENT TO MED. CENTER			DATE DISCHARGED				
LABORATORY WORK			PHYSICAL EXAMINATION							TREATMENT		
DATE	TEST	RESULT	PRESENT ILLNESS, ONSET, ETC.							DATE	DRUG	DOSE
			SKIN AND MUCOUS MEMBRANE									
			EYES: PUPILS		REFLEXES		OTHER					
			LYMPH NODES			LUNGS						
			HEART			BLOOD PRESSURE						
			GENITALIA									
			NERVOUS SYSTEM									
			NOTES:									

TENNESSEE DEPT. PUBLIC HEALTH 233

PURPOSE: To provide a record of services rendered in health department clinics for diagnosis and control of venereal diseases, and for follow-up contacts to clinic cases.

EXPLANATION AND DEFINITIONS:

Date of Birth: Month, day and year.

Date Admitted: The date of the patient's first visit to the local health department for this service.

Date Reported: The date the Tennessee Department of Public Health is notified of the case of venereal disease by case report card.

Date Discharged: The date the patient is discharged from the medical center.

Diagnoses: This space is to be filled in when diagnosis is established. The following definitions will be used in the classification of cases.

SYPHILIS

Primary: The patient has a chancre at the time of diagnosis by the physician. A patient with syphilis who does not have a chancre at time of diagnosis is not a primary case.

Secondary: The patient has secondary manifestations (mucous patches, rash, condylomata, etc.) at the time of diagnosis by the physician. A patient with syphilis who does not have secondary lesions at time of diagnosis is not a secondary case.

Early Latent: The patient has syphilis of less than four years' duration which is clinically non-recognizable. The diagnosis is based on history of symptoms, history of inadequate previous treatment and/or two or more positive serologic tests for syphilis, and a negative spinal fluid examination.

Late Latent: Same as early latent, except that the duration of the disease is *four years or more*.

When a diagnosis of latent syphilis is made and the duration of infection is indeterminable, the case may be classified as *Early Latent* if the patient is less than thirty years of age or *Late Latent* if the patient is thirty or more years of age.

Late: The patient, who at the time of diagnosis has any of the late manifestations of syphilis, such as asymptomatic or symptomatic neurosyphilis, cardiovascular syphilis, osseous or late mucocutaneous manifestations, etc.

Congenital: The patient with a definite history of prenatal infection, active clinical manifestations of congenital syphilis, or with any of the stigmata of congenital syphilis.

A DIAGNOSIS OF SYPHILIS SHOULD NEVER BE MADE ON THE BASIS OF A SINGLE POSITIVE SEROLOGIC TEST IN THE ABSENCE OF SIGNS AND SYMPTOMS OF THE DISEASE OR IN THE ABSENCE OF A DEFINITE HISTORY OF PREVIOUS TREATMENT.

GONORRHEA*

"A purulent infection of one of the mucous membranes, most frequently of the genital tract. Chronic and relapsing inflammatory conditions with discharge are common at the site of the original attack. The disease may spread to adjacent or remote tissues causing acute or chronic processes, among which are arthritis and endocarditis."

CHANCROID*

"Occurring as an acute, localized, autot inoculable venereal disease of both sexes, chancroid is characterized clinically by necrotizing ulcerations at the site of inoculation. There is frequently an inflammatory swelling and suppuration of the adjacent lymph nodes. Laboratory identification of the *Hemophilus ducreyi* and immunologic reactions (skin tests) are of diagnostic value but the chief reliance must be placed upon the clinical signs and symptoms, history of exposure and exclusion of primary syphilis and lymphogranuloma venereum."

GRANULOMA INGUINALE *

"A chronic infection of the skin and mucous membranes of the external genital organs. The primary lesion is a small nodule or papule which becomes a creeping, serpiginous ulcer. This ulcer extends peripherally with the formation of masses of fibrous tissue, often exuberant and mixed with or bordered by active granulomatous lesions. New lesions may occur by auto-inoculation, and coalesce with older ones. The disease shows a predilection for warm and moist surfaces such as folds between the scrotum and thighs in the male and the labia and vagina in the female; if neglected for several years may cause serious destruction of genital organs and spread to other parts of the body. Clinical diagnosis is confirmed by the examination of scrapings from ulcers for the causative organism."

LYMPHOGRANULOMA VENEREUM*

"Recognition of the disease by adenopathy, inguinal in male, pelvic in female, and history of exposure to venereal infection. Characterized by small herpetiform lesion at point of inoculation on external genitalia or uterine cervix (rarely in mouth), usually transitory, followed by massive subacute or chronic adenitis and periadenitis, usually with multiple foci or suppuration. Associated with constitutional symptoms, fever, prostration, loss of weight, arthritic affections, and skin reactions. Clinical diagnosis may be confirmed by Frei antigen intradermal test."

* Description from "The Control of Communicable Diseases", American Public Health Association, 1945.

Date of Laboratory Examination: This should show the date on which specimen is collected and not the date on which the laboratory report is received.

Physical Examination: These spaces are self-explanatory and are used to record clinical findings at the time of admission to the clinic.

Treatment: Date, Drug, Dose: These items show the date the patient received his treatment, the kind of drug, and the dosage administered.

EPIDEMIOLOGICAL REPORT

Date of Report: Date interview is made.

Address: Extra space is to be used for additional information to help in locating suspect.

Reason for Investigation: a. Contact: Check type of contact. b. Other: Check appropriate space.

USED BY: Clinic physician, nurse, interviewer and clerical assistant at clinic.

OFFICE MECHANICS AND FILING: A Venereal Disease Record will be made on all persons coming to the clinic for diagnostic purposes. If a person comes to the clinic voluntarily, a Venereal Disease Record without Epidemiological Report will be used. If a person comes to the clinic as a result of investigation, the Venereal Disease Record on the back of his Epidemiological Report will be used.

At the time of interview of a patient infected with a venereal disease, an Epidemiological Report form for each contact named will be made by the interviewer.

USE OF EPIDEMIOLOGICAL REPORT FORM:

1. *White* copy to be used by person doing investigation. Notes regarding investigation should be given under "Notes" on the back. When the investigation has been completed, this form should be attached to the Venereal Disease Record until disposition is made. Then it may be removed and filed in "Investigation Closed This Month File."
2. *Pink* copy will be filed in "Contacts Named This Month," and used to determine the number of contacts named.

3. *Yellow* copy will be sent with the patient, if and when he is sent to the medical center. If a patient does not go to the medical center immediately, all *Yellow* copies of his contacts should be attached to his Venereal Disease Record and, if and when he does go to the medical center, these copies should be sent with him. If the patient has not gone to the medical center by the end of the month, these copies of his contacts may be removed and destroyed.
4. *Yellow Card* will be filed in a "Contact and/or Suspect File," and back side will be used as Venereal Disease Record when he reports to the clinic.
5. If the contact or suspect named lives in another county in the state, the *White* copy and *Yellow Card* will be sent to the health department in that county. *Yellow* and *Pink* copies are to be used as above.
6. If the contact or suspect named lives outside the state, the *White* copy will be sent to that state health department. The *Yellow Card* may be destroyed. *Yellow* and *Pink* copies are to be used as above.
7. If a contact is named at the medical center, the local health department will receive all copies except the *Pink* copy. The *White* copy and the *Yellow Card* will be used as above and the *Yellow* copy will be returned to medical center with results indicated when investigation is closed. If contact is named in a health department outside the state, a complete set of Epidemiological Report forms will be made by the clerk, the *Pink* copy destroyed and others used as above.

In order to process this material and to prepare monthly reports, the following files will be set up:

ACTIVE:

1. Contact and/or Suspect.
2. Diagnostic.
3. Disposition This Month.
4. Investigation Closed This Month.
5. Contacts Named This Month.
6. Treatment or Observation.

CLOSED:

1. Venereal Disease Record - filed alphabetically.
2. Epidemiological Report (white) - filed alphabetically by suspect's name.
3. Epidemiological Report (pink) - filed alphabetically by informant's name.

These files may be used as follows for completion of Clinic Monthly Report, Form 8954-A (Form 238):

A-1, 2, and 3 of Clinic Monthly Report will be obtained from "Disposition This Month" file.

B-1, 2, 3, and 4 of Clinic Monthly Report will be obtained from the cards of persons infected with venereal disease included in "Disposition This Month" file - those cards used for A-2.

C and D will be obtained from cards in "Disposition This Month" file that are not included in A-1, 2, or 3.

E-1 and 2 will be obtained from "Contacts Named This Month" file.

F: a-1, 2, and 3 will be obtained from "Investigation Closed This Month" file.

F: b-1, 2, and 3 will be obtained from infected cases included in F: a-1, 2, and 3.

When *Clinic Monthly Report* has been made:

- a. Records in "*Disposition This Month*" file should be filed in "Treatment or Observation" file or "Venereal Disease Records Closed" file.
- b. Records in "*Investigation Closed This Month*" file should be filed in "Epidemiological Report (white) Closed" file.
- c. Records in "*Contacts Named This Month*" file should be filed in "Epidemiological (pink) Report Closed" file.

COMMENT: *Venereal Disease Record*, Form 233, and *Epidemiological Report* form are designed to replace all venereal disease records that have previously been used in local health departments. When this record is installed and properly kept, all venereal disease records should be in one file and easily accessible to health department personnel. By following the exact procedure as outlined, reports from all local health departments will be interpreted alike.

Pages 234-236 missing

MEDICAL CERTIFICATE FOR MARRIAGE LICENSE - FORM 237
 SIZE 11" x 8½"

FRONT

STATE OF TENNESSEE
 DEPARTMENT OF PUBLIC HEALTH
 NASHVILLE

MEDICAL CERTIFICATE FOR MARRIAGE LICENSE

THIS IS TO CERTIFY that I have on file, and will keep on file and available for inspection by a legally authorized representative of the Tennessee Department of Public Health upon request, a laboratory report of a , laboratory number , performed
(Name of Serologic Test)
 on by the and signed by
(Date of Test) (Name of Laboratory) (Name of Person Signing Laboratory Report)
 for Race Sex Age
(Name of Applicant)

.....
(Street Address or RFD if Rural) (City) (County) (State)

I ALSO CERTIFY that I examined
(Name of Applicant) *

Race Sex Age , who is the same person referred to above, on
(Date of Examination)

according to the provisions of Chapter 122, Public Acts of 1939, and the regulations of the Tennessee Department of Public Health and, in my opinion, this person is not infected with syphilis, gonorrhea or another venereal disease or is not in a stage of a venereal disease which may become communicable.

Signature of Physician M.D.

Date Address of Physician

THIS CERTIFICATE IS NOT VALID AND MUST NOT BE ACCEPTED BY CLERK FOR ISSUANCE OF MARRIAGE LICENSE UNLESS ALL ITEMS ABOVE ARE COMPLETELY FILLED IN.

THIS IS TO CERTIFY that I am the applicant referred to in the above certificate.

Signature
(To be signed by applicant in presence of physician)

Address

(See Reverse Side)

BACK

PLEASE TAKE NOTICE

Requirements set out by Chapter 122, Public Acts of 1939, and the Regulations of the Tennessee Department of Public Health pertaining to the prevention of the spread of venereal diseases through marriage:

1. Each applicant must file a properly executed certificate with the County Court Clerk before a marriage license can be issued legally.
2. A standard approved laboratory blood test shall be made on a specimen of blood from each applicant.
3. The blood test shall be made by a laboratory approved by the Commissioner of Public Health. Laboratories of state health departments, United States Army, United States Navy, United States Public Health Service, and the author serologists are the only interstate laboratories approved for making serologic tests for applicants for marriage licenses in Tennessee.
4. The blood test shall be made within thirty (30) days prior to the time the license is issued.
5. The medical certificate shall be signed by a medical graduate of a reputable medical school who is licensed to practice medicine in the state in which he resides.
6. The licensing officer shall attach the certificates of both applicants to the marriage license and they shall remain attached and filed in the office of the County Court Clerk.
7. No person authorized to perform a marriage ceremony shall perform such a ceremony unless the certificates of both applicants are attached to the marriage license.
8. A diagnosis of syphilis shall be based upon the finding of a positive darkfield test, or a positive test and signs and symptoms of the disease, or two positive blood tests.
9. A person with syphilis of less than four years duration who has not been given twenty (20) doses each of an approved arsenical and a heavy metal within a period of not over eighteen (18) months shall be considered to have the disease in a communicable stage.
10. The decision as to the communicability of gonorrhea in any applicant with the disease shall be left to the discretion of the physician.
11. Any person violating the provisions of the Act is subject to a penalty of not less than fifty nor more than one hundred dollars.
12. Any person who shall wilfully and knowingly misrepresent, falsify, or issue a false certificate shall be subject to a penalty of not less than fifty nor more than one hundred dollars.

MEDICAL CERTIFICATE FOR MARRIAGE LICENSE - FORM 237

PURPOSE: To provide a record showing certification of freedom from syphilis, gonorrhea and other venereal disease, or that such a disease is not in a state which may become communicable of an applicant for marriage license.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Private physicians and county court clerks.

OFFICE MECHANICS AND FILING: These certificates are to be requisitioned from the Tennessee Department of Public Health by the local health departments for distribution to private physicians. The instructions for the use of this form are on the back of the certificate.

11-3-47

VENEREAL DISEASE CONTROL ACTIVITY REPORT, FORM 8954-A (FORM 238)
SIZE 8" x 10½"

FRONT

Form 8954-A
FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE
Division of Venereal Diseases
Revised June 1948

Budget Bureau No. 68-R034.1.
Approval expires 6-31-48.

QUARTERLY VENEREAL DISEASE CONTROL ACTIVITY REPORT
(For Clinic and Epidemiologic Activities)

Jurisdiction Period from
To

A. NUMBER OF DIAGNOSTIC OBSERVATIONS COMPLETED IN CLINICS IN THIS JURISDICTION:

1. Not infected with a venereal disease.....
2. Infected with a venereal disease.....
3. Dropped or transferred without completion of diagnosis.....

	SYPHILIS				GONORRHEA	OTHER V. D.
	PRIMARY AND SECONDARY	EARLY LATENT	CONGENITAL	OTHER		
B. NUMBER OF CASES (not previously treated) DIAGNOSED AS INFECTED OR ADMITTED TO CLINICS:						
1. Referred to Rapid Treatment Center or other in-patient care for treatment.....						
2. Referred to private physicians for treatment.....						
3. Referred to clinics outside this jurisdiction for treatment.....						
4. Admitted to treatment in clinics in this jurisdiction.....						
C. NUMBER OF CASES (previously treated) ADMITTED TO CLINICS FOR FURTHER TREATMENT OR OBSERVATION.....						
D. NUMBER OF CASES (previously treated) REFERRED TO RAPID TREATMENT CENTERS OR OTHER IN-PATIENT CARE IN ORDER TO COMPLETE TREATMENT.....						
E. NUMBER OF CONTACTS OBTAINED BY STAFF INTERVIEW OF—						
1. Patients in clinics.....						
2. Patients of private physicians, institutions, etc.....						
F. RESULTS OF EPIDEMIOLOGIC INVESTIGATIONS:						
(a) Number completed:						
1. Contacts.....						
2. Other suspects*.....						
3. Lapsed cases.....						
(b) Persons brought to treatment as a result of these investigations:						
1. Contacts.....						
2. Other suspects*.....						
3. Lapsed cases.....						

*Persons suspected of having V. D. for any reason other than contact report.

Date prepared, 19.....

Submitted by
(Signature)

(Title)

To be submitted to U. S. P. H. S. through the State Health Department by all health units (except RTC's) performing any of the activities included in this report
(See Reverse for Instructions)

10-68908-1

BACK

8954-A—Revised

INSTRUCTIONS AND DEFINITIONS

A. Number of Diagnostic Observations Completed in Clinics in This Jurisdiction:

For purposes of this report, a diagnostic observation is an examination of a person to determine the presence or absence of venereal disease other than observations to determine response to therapy. It is completed when the doctor has decided on all venereal diseases for which he is observing the person. The case may be counted as "infected" when the decision is made that any venereal disease is present but cannot be counted as "not infected" until a decision is made on all venereal diseases for which the person is being observed. Count as "dropped" when the observation is not completed because of nonattendance. Do not make separate entries on lines 1 and 2 if an individual is infected with one disease but not with another. If infected with any venereal disease enter *only* on line 2.

B. Number of Cases (not previously treated) Diagnosed as Infected or Admitted to Clinics:

This section is only for cases not previously treated for their *current* infection(s). Include, according to appropriate disposition of case, all infections diagnosed in this unit (possible entry on any line) or infections diagnosed elsewhere (entry on line 4 or on line 1, if it is State policy that all RTC admissions be made through the local health department).

C. Number of Cases (previously treated) Admitted to Clinics for Further Treatment or Observation:

Include all admissions to this unit who have received previous treatment elsewhere for their current infection. Do not include readmissions.

D. Number of Cases (previously treated) Referred to Rapid Treatment Centers or Other In-Patient Care in Order To Complete Treatment:

This item should include only cases previously admitted to clinic preparing this report. Include subsequent referrals to the RTC provided that they are for a relapse of the infection previously treated. If referral is for a new infection not treated, it should be reported in B-1.

E. Number of Contacts Obtained by Staff Interview:

Include all contacts named, even if known to be under treatment at the time reported. Include only contacts obtained by the staff of this jurisdiction regardless of where to be investigated. Do not include contacts obtained elsewhere but reported to this jurisdiction for follow-up. Column entries are to be made corresponding to the diagnosis of the *informant*. If informant has more than one disease, count the contact named as a contact to each disease to which exposed or possible source. Contacts obtained by staff interview of patients of private physicians who are referred to an RTC should be included in E-1.

F. Results of Epidemiologic Investigations:

(a) Enter the number of investigations *completed* during the period, by type, including all dispositions: Suspect is found, upon investigation, to have moved out of area; suspect is brought to treatment; cannot be located; etc. (b) Show in 1 and 2 only the new cases *previously untreated for this infection* that were brought to treatment (clinic or physician) as a result of investigations completed this period. Make entries according to disease and stage brought to treatment and type of case. Enter diagnosis of lapsed cases returned to treatment in 3.

TO BE PREPARED FOR QUARTERS ENDING SEPTEMBER 30, DECEMBER 31, MARCH 31, JUNE 30

The State health department may submit a one-page total to the USPHS instead of individual unit reports, if desired. RTC's and In-Patient Bed Contract Projects will not prepare this report but will submit instead the "Report of In-Patient Care."

U. S. GOVERNMENT PRINTING OFFICE 16-62395-1

PURPOSE: To furnish a monthly summary of venereal disease clinic activities for the records of the local health agency, the Tennessee Department of Public Health, and the U. S. Public Health Service. The activities of all the clinics operated by the local official health agency in a city or county unit should be covered in one report.

EXPLANATION AND DEFINITIONS:

Classification of Syphilis: See instructions for use of Venereal Disease Record, Form 233, for definitions to be used in the classification of cases of syphilis.

A. Number of Diagnostic Observations Completed in Clinics in This Jurisdiction:

For purposes of this report, a diagnostic observation is an examination of a person to determine the presence or absence of venereal disease other than observations to determine response to therapy. It is completed when the doctor has decided on all venereal diseases for which he is observing the person. The case may be counted as "infected" when the decision is made that any venereal disease is present but cannot be counted as "not infected" until a decision is made on all venereal diseases for which the person is being observed. Count as "dropped" when the observation is not completed because of nonattendance. Do not make separate entries on lines 1 and 2 if an individual is infected with one disease but not with another. If infected with any venereal disease enter *only* on line 2.

B. Number of Cases (not previously treated) Diagnosed as Infected or Admitted to Clinic:

This section is only for cases not previously treated for their *current* infection (s). Include, according to appropriate disposition of case, all infections diagnosed in this unit (possible entry on any line) or infections diagnosed elsewhere (entry on line 1; it is State policy that all RTC admissions be made through the local health department).

C. Number of Cases (previously treated) admitted to Clinics for Further Treatment or Observation:

Include all admissions to this unit who have received previous treatment elsewhere for their *current* infection. Do not include readmissions.

D. Number of Cases (previously treated) Referred to Rapid Treatment Centers or Other In-Patient Care in Order to Complete Treatment:

This item should include only cases previously admitted to clinic preparing this report. Include subsequent referrals to the RTC provided that they are for a relapse of the infection previously treated. If referral is for a new infection not treated, it should be reported in B-1.

E. Number of Contacts Obtained by Staff Interview:

Include all contacts named, even if known to be under treatment at the time reported. Include only contacts obtained by the staff of this jurisdiction regardless of where to be investigated. Do not include contacts obtained elsewhere but reported to this jurisdiction for follow-up. Column entries are to be made corresponding to the diagnosis of the *informant*. If informant has more than one disease, count the contact named as a contact to each disease to which exposed or possible source. Contacts obtained by staff interview of patients of private physicians who are referred to an RTC should be included in E-1.

F. Results of Epidemiologic Investigations:

(a) Enter the number of investigations *completed* during the period, by type, including all dispositions: Suspect is found, upon investigation to have moved out of area; suspect is brought to treatment; cannot be located; etc. (b) Show in 1 and 2 only the new cases *previously untreated for this infection* that were brought to treatment (clinic or physician) as a result of investigations completed this period. Make entries according to disease and stage brought to treatment and type of case. Enter diagnosis of lapsed cases returned to treatment in 3.

Please enter on the bottom of this report the number of darkfield examinations done during the period.

USED BY: Clerk and health officer.

OFFICE MECHANICS AND FILING: A complete summary record for each full-time city or county unit should be prepared monthly and in triplicate. Two of these copies should be sent to the Tennessee Department of Public Health in time to reach the office not later than the fifth of the month.

TO BE PREPARED FOR EACH MONTH

VENEREAL DISEASE TRANSFER RECORD - FORM 239
SIZE 5" x 8"

VENEREAL DISEASE TRANSFER RECORD					
NAME _____		COLOR _____	SEX _____	DATE OF BIRTH _____	MARITAL STATUS _____
HAS MOVED FROM _____			COUNTY _____		
TO _____			COUNTY _____		
DATE ADMITTED _____		DATE REPORTED ON MORBIDITY CARD _____			
DARKFIELD: DATE _____		RESULTS _____	SITE OF LESION _____		
FIRST WASSERMANN: DATE _____		RESULTS _____	LAST WASSERMANN: DATE _____		RESULTS _____
SPIRAL FLUID: DATE _____		RESULTS _____	SMEAR: DATE _____		RESULTS _____
PAST TREATMENT (NUMBER OF DOSES): NEOSPHENAMINE _____			BISMUTH _____		
MERCURY _____			KI _____	OTHER _____	
LAST COURSE OF TREATMENT CONSISTED OF _____					
DATE OF LAST TREATMENT _____			REGULARITY OF CLINIC ATTENDANCE _____		
DRUG IDIOSYNCRASY _____					
SIGNIFICANT CLINICAL FINDINGS _____					
REMARKS: _____					
DATE _____					
			SIGNATURE _____		
			HEALTH DEPARTMENT _____		

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 239

PURPOSE: A record to be used when a venereal disease case moves from one health jurisdiction to another. It is a composite history of the case containing the information necessary for the patient's future treatment.

EXPLANATIONS AND DEFINITIONS: Complete information as to the patient's new address should be given, street address and information for locating patient.

Regularity of Clinic Attendance: A short explanation of the patient's regularity of treatment including the extent of irregularity and possible explanation of same.

Drug Idiosyncrasy: Is the patient sensitive to arsenic, bismuth, etc.? How the sensitivity is manifest.

Significant Clinical Findings: Only those clinical findings - specific or non-specific - which would have a direct bearing on how the patient should be treated. Examples: syphilitic aortitis, chronic nephritis, syphilis of the liver, etc.

USED BY: Health officer and clerk.

OFFICE MECHANICS AND FILING: The record should be made out in duplicate by the health officer, one copy to be sent to the health officer of the area to which the patient has moved, and one to be kept in local files. The record *should not* be given to the patient for delivery, and *should not* be used for inter-state notification.

VENEREAL DISEASE MEDICAL CENTER RECORDS
FORMS 240, 241, 242, 243, 244

240
241
242
243
244

ORDER OF ISOLATION AND QUARANTINE BY HEALTH OFFICER - FORM 240
SIZE 11" x 8½"

ORDER OF ISOLATION AND QUARANTINE BY HEALTH OFFICER

STATE OF TENNESSEE
CITY OR COUNTY OF _____

TO THE SUPERINTENDENT OF THE _____
(Name of Medical Center)

(Name of Patient) (Address) (Color) (Sex) (Age)

by medical examination has been found to be infected with _____
(Name of Disease or Diseases)

as defined in Chapter 73, Public Acts of 1943 and the Code of Tennessee, and under the authority vested in me
by Chapter 73, Public Acts of 1943 and the Code of Tennessee is hereby quarantined in the _____

_____ until discharged by the medical officer in charge as no
(Name of Medical Center)
longer communicable or no longer in a stage of the disease in which an infectious relapse may occur.

WITNESS MY HAND, this _____ day of _____, 194_____

Health Officer

Authorized Deputy

This is to certify that I examined _____ on
_____, 194_____, and the findings of the physical examination and
laboratory were as follows: _____

Summary of previous treatment: _____

Health Officer

Authorized Deputy

_____ was admitted to the _____
(Name of Medical Center)

for quarantine on _____
(Date)

(Medical Officer in Charge)

240)
241)
242) -a
243)
244)

ORDER OF ISOLATION AND QUARANTINE BY COURT - FORM 241
SIZE 11" x 8½"

ORDER OF ISOLATION AND QUARANTINE BY COURT

STATE OF TENNESSEE

COUNTY OF _____

On the _____ day of _____, 194____
_____ of the aforesaid State and County was brought before
me on the charge that said _____ was infected with a venereal disease and
after examination as provided by law, (Chapter 73, Public Acts of 1943), the court found that the said _____
_____ is so infected and is therefore a proper person to be
committed to _____ Medical Center.

It is therefore ordered and adjudged by the court that _____
be and is hereby committed to said institution, there to remain until released by the Health Officer as no
longer communicable or no longer in a stage of the disease in which infectious relapse may occur, or re-
leased by this Court.

This _____ day of _____, 194____

(List Title Here)

FORMAL NOTICE OF QUARANTINE - FORM 242
SIZE 5½" x 8½"

240)
241)
242) -b
243)
244)

FORMAL NOTICE OF QUARANTINE

STATE OF TENNESSEE

CITY OR COUNTY OF _____

TO: _____
(Name of Patient)

As provided in Chapter 73, Public Acts of 1943 and the Code of Tennessee, you are hereby being placed under quarantine in the _____ Medical Center because of being infected with _____
(Disease or Diseases)

You will continue under quarantine in said hospital until discharged as no longer communicable or no longer in a stage of the disease in which infectious relapse may occur.

Health Officer

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 242

EXAMINATION AND TREATMENT RELEASE - FORM 243
SIZE 5½" x 8½"

EXAMINATION AND TREATMENT RELEASE

I, _____, agree of my own will and under no duress to submit myself to such physical examination and related procedures as the State, County, or Municipal Health Officer shall deem necessary to determine the present condition of my health. I further agree, under his advice and direction, to avail myself of such means for continued medical or hospital care that will fully satisfy the requirements of Chapter 73, Public Acts of 1943, State of Tennessee, and the provisions of Regulation 13A and B of the Tennessee Department of Public Health.

Signature: _____

Date: _____

Witness: _____

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 243

240)
241)
242) -c
243)
244)

VOLUNTARY PATIENT CONSENT FOR ADMISSION TO MEDICAL CENTERS - FORM 244
SIZE 11" x 8½"

FRONT

VOLUNTARY PATIENT CONSENT FOR ADMISSION TO MEDICAL CENTERS

In consideration of my admission to state-maintained medical centers for treatment and my maintenance therein at no expense to me, I, _____, do hereby agree as follows:

1. To go voluntarily to the _____ Tennessee Medical Center for the treatment of a venereal disease.
2. To submit myself to such physical examination, treatment and related procedures as the Medical Officer may deem necessary to the treatment of my condition, and to abide by all rules and regulations now or hereafter in force at such Medical Center.
3. To irrevocably consent to remain at such Medical Center until such disease is, in the opinion of the Medical Officer in Charge, no longer communicable or no longer in a stage in which infectious relapse is apt to occur; but this irrevocable consent shall not be construed as authorizing any involuntary detention therein for a period of more than ten weeks from the date of my entry therein.
4. To waive any and all rights of action which I may have against any of the officers or personnel of said Medical Center except that this waiver shall not be construed as waiving any right of action which I may have against them or any of them by proven acts of negligence or malpractice.

Date

Signature of Patient

Witnesses:

240)
241)
242)-d
243)
244)

BACK (FORM 244)

Health Department

Tennessee

RE: _____ WM _____ WF _____ CM _____ CF _____ Age _____
 Last Name First Name

Street Number Town County State
Referred for: Diagnosis () Treatment ()

DIAGNOSIS: (Syphilis) Primary () Secondary () Early Latent () Late Latent ()
Late () Asymptomatic Neuro () Congenital ()
Gonorrhea () Granuloma Inguinale () Lymphogranuloma Venereum () Chancroid ()

LABORATORY REPORTS (Darkfield, Serology, Spinal Fluid, Cultures, and Smears)

<u>Date</u>	<u>Test</u>	<u>Result</u>	<u>Date</u>	<u>Test</u>	<u>Result</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

TREATMENT

Date first injection _____ Date last injection _____

Total arsenical injections to present _____ Heavy metal _____

Units of penicillin _____

REMARKS (Special treatment, special drugs, reactions, relapse, etc.)

_____ Health Officer

240)
241)
242)-1
243)
244)

VENEREAL DISEASE MEDICAL CENTER RECORDS
FORMS 240, 241, 242, 243, 244

PURPOSE: To be used to quarantine a venereal disease patient legally in the medical centers and to obtain a voluntary treatment release from the patient.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Health officer and clerk.

OFFICE MECHANICS AND FILING: These forms are to be used for all patients who are to be admitted to a Tennessee Medical Center.

Form 240 - Order of Isolation and Quarantine by Health Officer is filled out as indicated and signed by the health officer or his authorized deputy. This form is sent to the medical center when the patient is admitted under quarantine order. This is only used in health departments in the county in which the medical center is located.

Form 241 - Order of Isolation and Quarantine by Court: In the event the patient refuses to sign Form 244 and go to the medical center voluntarily, or refuses to accept a quarantine order of the health officer (Form 240) and sign Form 243, Form 241 is to be completed by the health officer and signed by the general sessions court judge or magistrate. This will put the patient under the order of isolation and quarantine by the court. This form is sent to the hospital when the patient is admitted.

Form 242 - Formal Notice of Quarantine is to be filled out as indicated, signed by the health officer and sent to the medical center with the patient.

Form 243 - Examination and Treatment Release is to be signed by patient to be admitted by quarantine order. This is to be sent to the medical center along with Form 240 and 241, depending on which form is to be used.

Form 244 - Voluntary Patient Consent for Admission to Medical Centers is to be used for the admission of all voluntary patients to the medical centers. In this event, it will not be necessary to complete any of the other forms.

The back of this form should be completed so that the medical officer in charge of the medical center will have complete information concerning diagnosis, previous treatment and contacts named by the patient. This form is made in duplicate. One copy is to be sent with patient to medical center, the other copy is kept in the health department.

Pages 245-279 missing

APPLICATION FOR PERMIT FOR IMPOUNDAGE CONSTRUCTION - FORM 280
 SIZE 11" x 8½"

STATE OF TENNESSEE
 DEPARTMENT OF PUBLIC HEALTH
 NASHVILLE

APPLICATION FOR PERMIT FOR IMPOUNDAGE CONSTRUCTION

NAME OF APPLICANT _____

ADDRESS _____

APPLICATION IS FOR: NEW CONSTRUCTION _____ RAISING LEVEL OF EXISTING IMPOUNDAGE _____

LOCATION OF PROJECT: COUNTY _____ CIVIL DISTRICT _____

PURPOSE OF PROJECT _____

APPROXIMATE NUMBER OF INHABITANTS WITHIN ONE MILE OF THE SHORELINE OF THE PROPOSED RESERVOIR _____

AREA IN ACRES TO BE INUNDATED _____ LENGTH OF DAM _____ HEIGHT OF DAM _____

DIAMETER OF DRAIN AT BOTTOM OF DAM _____ ESTIMATED FLUCTUATION OF WATER LEVEL _____

_____ ESTIMATED COST OF PROJECT _____

WILL SUFFICIENT FUNDS BE AVAILABLE TO CARRY OUT MAINTENANCE REGULATIONS? _____

APPROXIMATE DATE WHEN IT IS DESIRED TO START CONSTRUCTION _____

APPROXIMATE DATE OF COMPLETION OF CONSTRUCTION _____

IN MAKING THIS APPLICATION, I CERTIFY THAT I AM FAMILIAR WITH THE CONTENTS OF CHAPTER 41, PUBLIC ACTS OF 1945, AND THE REGULATIONS PROMULGATED UNDER THAT ACT WHICH PERTAIN TO IMPOUNDAGE CONSTRUCTION, IMPOUNDAGE, AND MAINTENANCE OF IMPOUNDED WATERS.

* DATE _____ SIGNATURE OF APPLICANT _____

THIS FORM MUST BE SUBMITTED IN DUPLICATE

AN ACCURATE PLAT OF THE AREA TO BE EFFECTED, SHOWING CONTOURS AND MAXIMUM AND MINIMUM WATER LEVELS, MUST BE ATTACHED.

PERMIT FOR IMPOUNDAGE CONSTRUCTION

THE ABOVE APPLICANT, HAVING COMPLIED WITH SECTIONS 3 AND 4 OF CHAPTER 41, PUBLIC ACTS OF 1945, AND REGULATIONS PROMULGATED UNDER THAT ACT, IS HEREBY GRANTED A PERMIT TO PROCEED WITH CONSTRUCTION OF THE ABOVE MENTIONED PROJECT.

PERMIT NUMBER _____

DATE _____

 COMMISSIONER OF PUBLIC HEALTH

APPLICATION FOR PERMIT FOR IMPOUNDAGE CONSTRUCTION - FORM 280

PURPOSE: To furnish information and to provide for the enforcement of Chapter 41, Public Acts of 1945.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Applicant for impoundage construction permit, sanitation officer, malaria control engineers of central office, and the Commissioner.

OFFICE MECHANICS, FILING, AND PROCEDURES: The completed form is submitted in duplicate to the State Department by the applicant for impoundage construction accompanied by an accurate plat of the area to be effected, showing contours and maximum and minimum water levels. The application is reviewed and the proposed site is inspected by a malaria control engineer of the State Department. Recommendations are then made to the Commissioner. If the application is approved, the copies are signed by the Commissioner, one copy returned to the applicant and the other filed in the State Department office.

11-3-47

APPLICATION FOR PERMIT FOR IMPOUNDAGE AND MAINTENANCE
OF IMPOUNDED WATER - FORM 281
SIZE 11" x 8½"

STATE OF TENNESSEE
DEPARTMENT OF PUBLIC HEALTH
NASHVILLE

APPLICATION FOR PERMIT FOR IMPOUNDAGE AND MAINTENANCE OF IMPOUNDED WATER

NAME OF APPLICANT _____

ADDRESS _____

LOCATION OF PROJECT, COUNTY _____ CIVIL DISTRICT _____

PROJECT CONSTRUCTED UNDER PERMIT NUMBER _____

THIS IS TO CERTIFY THAT THE ABOVE NAMED PROJECT HAS BEEN CONSTRUCTED IN ACCORDANCE WITH THE REGULATIONS PROMULGATED UNDER CHAPTER 41, PUBLIC ACTS OF 1945.

I ALSO CERTIFY THAT I AM FAMILIAR WITH THE CONTENTS OF CHAPTER 41, PUBLIC ACTS OF 1945, AND THE REGULATIONS PROMULGATED UNDER THAT ACT WHICH DEAL WITH THE IMPOUNDAGE AND MAINTENANCE OF IMPOUNDED WATERS AND THAT SUFFICIENT FUNDS ARE AVAILABLE TO PROPERLY MAINTAIN THE IMPOUNDAGE ACCORDING TO THE REGULATIONS OF THE DEPARTMENT OF PUBLIC HEALTH.

I HEREBY APPLY FOR A PERMIT TO IMPOUND AND MAINTAIN THE IMPOUNDAGE REFERRED TO IN THE ABOVE NAMED PROJECT.

IT IS DESIRED TO START THE IMPOUNDAGE ON _____, 19____

DATE _____ SIGNATURE OF APPLICANT _____

THIS FORM MUST BE SUBMITTED IN DUPLICATE

PERMIT FOR IMPOUNDAGE AND MAINTENANCE OF IMPOUNDED WATER

THE ABOVE APPLICANT, HAVING COMPLIED WITH THE LAW AND REGULATIONS PERTAINING TO IMPOUNDAGE CONSTRUCTION, IS HEREBY GRANTED A PERMIT TO IMPOUND WATER IN THE ABOVE NAMED PROJECT, STARTING ON THE _____

DAY OF _____, 19____

PERMIT NUMBER _____

DATE _____

COMMISSIONER OF PUBLIC HEALTH

APPLICATION FOR PERMIT FOR IMPOUNDAGE AND MAINTENANCE
OF IMPOUNDED WATER - FORM 281

PURPOSE: To furnish information and to provide for the enforcement of Chapter 41, Public Acts of 1945.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Applicant for impoundage and maintenance of impounded water permit, sanitation officer, malaria control engineers of central office, and the Commissioner.

OFFICE MECHANICS, FILING, AND PROCEDURES: The completed form is submitted in duplicate to the State Department by the applicant for impoundage and maintenance of impounded water permit. A malaria control engineer of the State Department inspects the projects and makes recommendations to the Commissioner. If the application is approved, the copies are signed by the Commissioner, one copy returned to the applicant, and the other filed in the State Department office.

11-3-47

Pages 282-299 missing

SANITARY SURVEY OF HOME - FORM 300
SIZE 4" x 6"

FRONT

DISTRICT _____		SANITARY SURVEY OF HOME	
OWNER _____			
ADDRESS _____			
LOCATION OF PROPERTY _____			
OCCUPANT _____			
	CODE	NOTES	
EXCRETA DISPOSAL	/		
	/		
	/		
WATER	/		
	/		
	/		
SCREENING	/		
	/		
	/		
OTHER	/		
	/		
	/		
DATE _____		INSPECTOR _____	

. BACK

[illegible]

PURPOSE: To provide initial and continuing record of sanitary inspections of homes.

EXPLANATION AND DEFINITIONS: The upper part of the card is self-explanatory. The lower part of the face of the card is so arranged to provide a double triangle block for notations in code of findings, and on the same line is a space for notes.

In the upper triangle of the block are entered findings at time of original survey, recorded as follows: "Approved" by a "0", and slightly, moderately or markedly unsatisfactory by 1, 2, 3, respectively. (See code on back of card). On face of card, under

"notes", opposite each item (as water, excreta disposal), add such notes as seem necessary to complete findings.

Code and notes are used on reverse of card in same way, for continuing record.

A correction, made after the initial survey, is to be coded "00" in the lower triangle of the proper space on the face of the card, in addition to the "0" for approval recorded on the back of the card.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: Face of the card is filled in by sanitarian on initial survey. Subsequent visits are recorded on back of this record. Cards for rural areas are filed alphabetically by civil districts, cards for urban districts are filed by street. Each district file has two sections; one for active cards and the other for inactive cards of the district. The active file includes the cards for which corrections have not been made. The inactive file includes the cards for which all corrections have been made. The number of the rural civil district is to be written in designated place.

INSTALLATION OR REPAIR RECORD OF SEPTIC TANK SYSTEM - FORM 301
SIZE 5½" x 8"

INSTALLATION OR REPAIR RECORD OF SEPTIC TANK SYSTEM	
OWNER'S NAME _____	ADDRESS _____
DATE _____	
SKETCH OF PROPOSED SYSTEM _____	To _____
ADDRESS _____	
LOCATION _____	

TYPE OF TANK _____	
MINIMUM SIZE _____	
MINIMUM FEET OF 4" FARM TILE IN _____	
DISTRIBUTION FIELD _____	

DEPTH IN INCHES OF STONE _____	
FINAL APPROVAL _____	DATE _____
SIGNED _____	
<small>NOTE: PLUMBER MUST NOTIFY THE _____ HEALTH DEPARTMENT (PHONE _____) WHEN THE SEPTIC TANK SYSTEM IS READY FOR INSPECTION. IF ANY SEPTIC TANK SYSTEM OR PART THEREOF IS COVERED BEFORE BEING REGULARLY INSPECTED AND APPROVED, IT SHALL BE UNCOVERED BY THE PLUMBER AT THE DIRECTION OF THE HEALTH OFFICER OR HIS AUTHORIZED REPRESENTATIVE.</small>	
<small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH 301</small>	

PURPOSE: To provide a record of septic tank system of home.

EXPLANATION AND DEFINITIONS: The record is so arranged as to provide space for:

1. Owner of property, address of property, and date of visit.
2. Sketch as to location of tank and disposal field.
3. To - Name of plumber or contractor doing work.
4. Address - Business address of above plumber or contractor.
5. Location - Address of location of property where work is to be done
6. Type of tank - Concrete, brick, concrete block, plastered, etc.
7. Minimum size - Size recommended by health department.
8. Distribution field - Width, depth and length of field.
9. Depth of inches of stone - Depth recommended by health department.
10. Final approval - When minimum requirements have been met.
11. Signature - By person making inspection.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This form should be filled out by the sanitarian on initial survey and should be completed in duplicate. The original is to be filed in the local health department, and the duplicate copy is to be retained by the owner. Records are to be filed in one alphabetical arrangement, by the name of owner.

COMMENT: This record provides for better information on the installation and exact location (on the lot) of private sewage disposal systems.

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COMPLAINT OF NUISANCE - FORM 302
SIZE 3" x 5"

FRONT

COMPLAINT OF NUISANCE	
Owner of Property _____	
Location of Nuisance _____	

Person reporting _____	
Address _____	
Type of Nuisance _____	
Date _____	Complaint received by _____
	(Over)

BACK

Action taken _____	

Date _____	Signed _____
TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 302	

PURPOSE: To provide a record form for both the report of a nuisance and the action taken.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: The face of this card is made out by the clerk or other person receiving report. It is then given to the sanitarian who makes the investigation and records the results on the back of the card and returns the card to clerk for filing.

Pages 303-310 missing

SANITARY SURVEY OF SCHOOL - FORM 311
SIZE 11" x 8½"

FRONT

SANITARY SURVEY OF SCHOOL

SCHOOL _____

PRINCIPAL _____

COUNTY _____

DISTRICT _____

ENROLLMENT _____

SECTION 1 - GROUNDS - 6

A. SITE: Graded, drained, no stumps, weeds, cleanly maintained area.	2								
B. LOCATION: Removed from heavy traffic, dust, noise, mosquito breeding.	2								
C. OUTDOOR EQUIPMENT: All-weather walks, foot mats, playground equipment, play period supervised.	2								

SECTION 2 - BUILDING - 12

A. CONDITION: Painted, good repair, tight foundation.	3								
B. ARRANGEMENT: Satisfactory rooms, entrances, exits, floor area, air space.	2								
C. FACILITIES: Safe steps, free of hazards.	2								
D. SEATING: Individual approved seats, properly arranged, maintained.	3								
E. FLOORS AND CLEANING: Tight, good repair, clean, approved cleaning method.	2								

SECTION 3 - WATER SUPPLY - 20

A. SOURCE: Approved supply, properly protected.	10								
B. DISPENSING: Approved fountain.	10								

SECTION 4 - TOILET FACILITIES - 20

A. TOILET ROOMS: Clean approved type, adequate, inspected daily, only tissue used.	10								
B. SEWAGE DISPOSAL: Approved disposal system, urinal provided.	10								

SECTION 5 - LAVATORY FACILITIES - 8

A. HAND WASHING: Adequate, soap in dispensers, individual towels.	6								
B. HEALTH PRACTICES: Hands washed after toilet, before lunch, supervised.	2								

SECTION 6 - HEATING AND VENTILATION - 10

A. HEATING: Approved unit.	3								
B. VENTILATION: Window ventilators, adjustable windows, thermometer.	3								
C. HUMIDITY: Humidifier, 2-5 gallon water daily each room.	4								

SECTION 7 - LIGHTING - 10

A. SOURCE: Windows 20%, direction, adequate artificial light, wall and ceiling painted.	5								
B. DISTRIBUTION: 15-foot candles, shades adjustable, windows clean.	5								

SECTION 8 - SCHOOL LUNCH 10

A. FACILITIES: Adequate approved facilities, dishes and utensils properly washed, disinfected, handled and stored; adequate hot water and refrigeration, approved milk, food properly stored, room free of flies, clean, openings properly screened.	8								
B. LUNCH: Properly supervised, health certificate hair net uniforms	2								

SECTION 9 - MISCELLANEOUS - 4

A. SAFETY: Traffic and accident safeguard.	1								
B. FIRST AID: Kit approved.	1								
C. WALL WRITING BOARDS: Properly located, cleaned.	1								
D. GENERAL: Approved wrap storage, metal wastebasket, neat surroundings.	1								
TOTAL	100								

DATE _____

SANITARIAN _____

BACK

NOTES ON CONFERENCES AND FIELD VISITS

DATE _____

WORKER

[illegible]

SANITARY SURVEY OF SCHOOL - FORM 311

PURPOSE: To provide continuous record of surveys of school building.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for scoring each item of environmental sanitation. The score for each item is indicated. On items representing the findings in a number of classrooms, as "Heating, Approved Unit," the average should be entered. Example: If type of heating in two out of three classrooms were satisfactory and one was unsatisfactory, the score for this item would be two, with explanatory note to be made on the back of the record.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time a sanitary survey of school building is made. These cards are filed alphabetically, in a separate folder. Subsequent partial inspections are recorded on the back of this card.

COMMENT: Card provides enough columns for regular inspections for four years. It is, therefore, easy to determine what progress in school sanitation is made from time to time.

11-3-47

SANITARY SURVEY OF SCHOOL - FORM 312
SIZE 11" x 8½"

SANITARY SURVEY OF SCHOOL

SCHOOL _____

PRINCIPAL.

COUNTY _____

DISTRICT _____

ENROLLMENT

SECTION 1 - GROUNDS - 6

A SITE: Graded, drained, no stumps, weeds,
cleanly maintained area.

B. LOCATION: Removed from heavy traffic, dust, noise, mosquito breeding.

C. OUTDOOR EQUIPMENT: All-weather walks, foot mats, playground equipment, play period supervised.

SECTION 2 - BUILDING - 12

A. CONDITION: Painted, good repair, tight foundation

B. ARRANGEMENT: Satisfactory rooms, entrances, exits, floor area, air space.

C. FACILITIES: Safe steps, free of hazards.

D. SEATING: Individual approved seats, properly arranged, maintained.

E. FLOORS AND CLEANING: Tight, good repair, clean, approved cleaning method.

SECTION 3 - WATER SUPPLY - 20

A. SOURCE: Approved supply, properly protected.

B. DISPENSING: Approved fountain.

SECTION 4 - TOILET FACILITIES - 20

A. TOILET ROOMS: Clean, approved type, adequate, inspected daily, only tissue used.

B. SEWAGE DISPOSAL: Approved disposal system, urinal provided.

SECTION 5 - LAVATORY FACILITIES - 8

A. HAND WASHING: Adequate, soap in dispensers, individual towels.

B. HEALTH PRACTICES: Hands washed after toilet, before lunch, supervised.

SECTION 6 - HEATING AND VENTILATION - 10

A. HEATING: Approved unit.

B. VENTILATION: Window ventilators, adjustable windows, thermometer.

C. HUMIDITY: Humidifier, 2-5 gallon water daily each room.

SECTION 7 - LIGHTING - 10

A. SOURCE: Windows 20%, direction, adequate artificial light. wall and ceiling painted.

B. DISTRIBUTION: 15-foot candles, shades adjustable, windows clean.

SECTION 8 - SCHOOL LUNCH - 10

A. FACILITIES: Adequate approved facilities, dishes and utensils properly washed, disinfected, handled and stored; adequate hot water and refrigeration, approved milk, food properly stored, room free of flies, clean, openings properly screened.

B. LUNCH: Properly supervised, health certificate hair net uniforms

SECTION 9 - MISCELLANEOUS - 4

A. SAFETY: Traffic and accident safeguard.

B. FIRST AID: Kit approved.

C. WALL WRITING BOARDS: Properly located,
cleaned.

D. GENERAL: Approved wrap storage, metal wastebasket, neat surroundings.

TOTAL

DATE _____

SANITARIAN.

SANITARY SURVEY OF SCHOOL - FORM 312
(SCHOOL COPY)

EXPLANATION AND DEFINITIONS: The front of this form is the same as Form 311. Refer to Form 311 for instructions as to use of record. This form is to be left at the school for the information of the teachers.

COMMENT: This record is printed on bond paper without the continuation record on the back.

11-3-47

SCORE SHEET FOR SCHOOL CAFETERIA - FORM 313
SIZE 11" x 8½"

FRONT

SCORE SHEET FOR SCHOOL CAFETERIA

School _____ No. of children served _____

Location _____ Meals prepared by _____

Principal _____

Cafeteria manager _____ Source of milk supply _____

Item	Value	
(a) FLOORS. Easily cleanable construction, smooth, good repair, clean	2	
(b) WALLS AND CEILING. Clean, good repair, painted light color	2	
(c) DOORS AND WINDOWS. Screened, good repair	4	
(d) LIGHTING. Window area to be 20 per cent of floor area or artificial lighting of at least 10-foot candle at a distance of 30 inches off floor.	3	
(e) VENTILATION. Air change sufficient to avoid disagreeable odors and condensation	3	
(f) TOILET FACILITIES. State standard, clean, good repair, toilet paper	10	
(g) WATER SUPPLY. Approved source, adequate supply	10	
(h) HANDWASHING FACILITIES. Wash basin (used for no other purpose), warm water, soap, towels which are clean	4	
(i) CONSTRUCTION OF UTENSILS AND EQUIPMENT. Easily cleanable construction, no corrosion, good repair, no chipped or cracked dishes	5	
(j) CLEANING OF EQUIPMENT AND UTENSILS. Three compartment vats, clean cases, counters, shelves, tables, refrigerators and stoves. Eating and drinking utensils thoroughly cleaned after each use	6	
(k) BACTERICIDAL TREATMENT OF EATING AND COOKING UTENSILS. Approved bactericidal treatment after cleaning: 3 minutes in boiling water, or 2 minutes in chlorine solution, drying cloths, if used, kept clean and used for no other purpose	10	
(l) STORAGE AND HANDLING OF UTENSILS. Stored above floor in clean place protected from dust, flies, rats, etc., inverted or covered when practicable—no handling of contact surface	4	
(m) DISPOSAL OF WASTE. Liquid waste in approved manner, garbage stored in tight, non-absorbent, washable receptacles, covered pending removal, removed frequently and receptacles washed to prevent nuisance	8	
(n) REFRIGERATION. Readily perishable foods stored at 50 degrees F. or less	3	
(o) QUALITY OF FOOD AND DRINK. Wholesome, no spoilage, milk and milk products of approved quality (pasteurized preferred)	6	
(p) STORAGE AND DISPLAY OF FOOD AND DRINK. No contamination by overhead leakage, submerging or unnecessary handling, not on floors subject to splash, no animals, rodents, roaches, etc., floor cleaning only after closing, dustless methods	6	
(q) CLEANLINESS OF EMPLOYEES. Health certificates. Clean uniforms used for no other purpose, hands clean, and hair neat	4	
(r) MISCELLANEOUS. Premises kept clean and neat, clean adequate lockers for employees' clothing; soiled linens, etc., kept in containers	4	
(s) FLIES UNDER CONTROL.	6	
TOTAL	100	

DATE: _____ Sanitarian _____

BACK

INSTRUCTIONS FOR USE IN CONNECTION WITH THE INSPECTION FORM FOR SCORING SCHOOL CAFETERIAS

FLOORS. Floors in all rooms where food is prepared and served should be of an impervious material, wood, concrete or tile, and have a smooth finish. If floor drains are used they shall be provided with proper traps to minimize odors and clogging. Under no circumstances should floors be dry swept while food is being prepared and served. Clean floors are conducive to clean food-handling methods.

WALLS AND CEILINGS. Walls and ceilings of all rooms in which food or drink is prepared or served shall be clean and in good repair. All walls and ceilings should be painted or finished in a color to reflect the maximum light, preferably light color.

DOORS AND WINDOWS. When flies are prevalent all openings shall be properly screened with 16 mesh wire or smaller to be approved. The screen wire must be in good repair. Doors shall be self-closing.

LIGHTING. Window area to be not less than 20 per cent of the floor area. The light shall be reasonably distributed. Ample light promotes cleanliness.

VENTILATION. All rooms in which food is stored, prepared or served shall be well ventilated. This item shall be deemed to have been satisfied if all rooms are adequately ventilated so as to be reasonably free from disagreeable odors and condensation.

TOILET FACILITIES. The toilet facilities provided on the premises shall be accepted, provided they are of the State Standard and properly maintained and toilet paper (commercial grade) is provided at all times. It will not be necessary to have separate toilets for those working in the cafeteria, but would be most desirable.

WATER SUPPLY. The supply must be from a protected source. No credit can be given unless water supply is located on school grounds. It is desirable that water under pressure be provided in all kitchens. Credit of not more than five points can be given if the supply is approved even though it has to be carried. Precautions must be taken if water is carried to protect it from dust, and other possible sources of contamination. In no instance is the 'common dipper' to be used for drinking purposes and then deposited in the water.

HANDWASHING FACILITIES. It is desirable that lavatory facilities be provided in the kitchen for employees with hot and cold running water under pressure. Ordinary wash basins may be approved if they are used for no other purpose. Soap, liquid to be preferred, and clean towels must be available at all times. Paper towels or individual cloth towels are to be used. Under no circumstances shall the dish washing vessels be used for handwashing. The workers must be cautioned at each inspection against returning from toilet and not washing hands. It must be understood that the use of washing facilities, soap and sanitary towels are essential to the personal cleanliness of food handlers.

CONSTRUCTION OF UTENSILS AND EQUIPMENT. All utensils and equipment must be in good repair and so constructed that they can be easily cleaned. Credit cannot be given where dishes, cups, glasses, etc., are found to be cracked or chipped.

CLEANING OF EQUIPMENT AND UTENSILS. Three compartment, stationary vats are necessary for full credit if chlorine is used for bactericidal treatment. If individual vats or vessels are used only half credit, or three points can be given. The vats and vessels must be of sufficient size to assure satisfactory use, and have a smooth surface. Counters, cases, refrigerators, shelves, and tables and stove must appear clean. All drinking and eating utensils must be thoroughly cleaned and effectively subjected to an approved bactericidal process after each use.

BACTERICIDAL TREATMENT OF EATING AND COOKING UTENSILS. Approved bactericidal treatment after cleaning of eating and drinking vessels must be practiced. This item shall be deemed to be satisfied if all utensils mentioned above are kept in boiling water for 3 minutes, or in a chlorine solution for 2 minutes. The solution should be not less than 100 parts per million, and not reduced to below 50 parts per million. All utensils should be submerged so that the chlorine solution will cover all parts of the vessels to be treated. Drying cloths may be used—not recommended—provided they are kept clean and not used for any other purpose. Under no circumstances can any credit be given where hot, or even boiling water, is poured over the utensils or vessels.

STORAGE AND HANDLING OF UTENSILS. All utensils must be stored, inverted or covered, in a clean, dry place protected from flies, dust and other contamination. No handling of contact surfaces is to be permitted. If the handling and storage of the equipment is not properly carried out the bactericidal treatment may be nullified.

DISPOSAL OF WASTE. Water-tight metal receptacles, at least two, with tight-fitting lids, must be provided at convenient locations, for liquid waste and wet garbage. The receptacles must be non-absorbent and cleaned and treated with chlorine solution as necessary to prevent odors. Dry garbage must be handled and stored in such manner as not to cause a nuisance or fire hazard. All waste, liquid or combustible, must be disposed of daily.

REFRIGERATION. Readily perishable food to be stored at 50 degrees F. or less.

FOOD AND DRINK. For fresh food and drink, no contamination by overhead leakage, submerging, or unnecessary handling. Food to be stored at least 12 inches above floors, and in such a manner as not to be subject to splash, or animals, rodents, roaches, etc. Flies properly controlled. Floor cleaning and dusting by dustless methods. This is to be done at least one hour before or after the serving or preparing of food. If bottle milk is stored in ice cold water, the water shall not cover the bottle. If the bottle is submerged, then contamination may be expected.

CLEANLINESS OF EMPLOYEES. All workers must wear clean uniforms while working in the cafeteria and kitchen. Hands and finger nails must be clean. Hair nets must be worn by female employees while engaged in preparing and serving of food.

HEALTH CERTIFICATE. Each employee must have a certificate from a physician stating that he or she is free from contagious and infectious diseases.

MISCELLANEOUS. Premises must be kept neat and clean at all times. Employee's clothing must not be kept in rooms where food is prepared, served or stored. Soiled linens should be kept in containers or laundry bags.

FLIES UNDER CONTROL. All supplementary means necessary for the elimination and control of flies must be practiced. If flies are present no credit for this item can be given.

SCORE SHEET FOR SCHOOL CAFETERIA - FORM 313

PURPOSE: To provide an inspection sheet for school cafeterias.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for the scoring of each item in food sanitation. The score for each of the items is indicated. Instructions for the use of this record in connection with the inspection form for scoring school cafeterias are printed on the back of the record.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an official inspection of the school cafeteria is made. The inspection records are filed alphabetically, in separate folders. Subsequent partial inspections are recorded on the back of the sanitary survey school card.

11-3-47

Pages 314-318 missing

PASTEURIZATION PLANT, DAIRY, PRODUCER, DISTRIBUTOR, AND
EATING AND DRINKING ESTABLISHMENT FORM - FORM 319
SIZE 11" x 8 1/2"

[illegible]

PURPOSE: To provide a record of visits, other than complete official inspections to pasteurization plant, dairy, producer, distributor, and eating and drinking establishment.

EXPLANATION AND DEFINITIONS: This form is so arranged as to provide space for recording visits to pasteurization plant, dairy, producer, distributor, and eating and drinking establishment, when sanitarian makes visits to these establishments for purposes other than the official monthly visit.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record is to be filed in the individual folder under the name of the pasteurization plant, dairy, producer, distributor, and eating and drinking establishment, with the monthly inspection sheets and correspondence for the individual establishment.

* Grade awarded is based not only on sanitation items shown on this sheet but also on grade of milk used for pasteurisation and on temperature and bacteriological results on other side.

BACK

Name of plant _____

MILK AND CREAM ANALYSES

HEALTH EXAMINATIONS

[illegible]

* Enter the temperature and the logarithm of the bacterial count in small figures in the upper half of the spaces, and the sum of the last four results in red ink in the lower half thereof. Whenever this sum exceeds 300 under temperature, or 17.93 under logarithm of count, the supply no longer complies with the grade A pasteurized milk requirements.

TENNISSET FORMER PACE A

PASTEURIZATION PLANT INSPECTION RECORD
U.S.P.H.S. FORM 8976 C (FORM 320)

PURPOSE: To provide a permanent record for the inspection of pasteurization plants.

EXPLANATION AND DEFINITIONS: The form is so arranged that each item number corresponds with that on the Pasteurization Plant Inspection Form, Form 323. This record is arranged to provide space for the recording of the inspections for a period of eighteen (18) months. It is, therefore, easy to determine what progress is made from time to time.

If warning of degrading is necessary and Form 326 is sent, a note to that effect is recorded on face of this record. If Notice of Degrading, Form 327, is sent, this is recorded on face of the record.

On the section for Milk and Cream Analyses on the back, information is recorded from Report of Analysis of Milk Sample, Form 328. In the section for health examinations, information from Health Certificate of Milk Handler, Form 329, is recorded.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an inspection is made of a pasteurization plant and is filed in a special ledger. Ledger sheets should be set up alphabetically by type of establishment, that is, pasteurization plants, producer-distributor dairies and plant-producer dairies.

BACK

Name of dairy _____

MILK AND CREAM ANALYSES

[illegible]

* Enter the temperature and the reductase hours or the logarithm of the bacterial count in small figures in the upper half of the space, and the sum of the last four results in red ink in the lower half thereof. Whenever this sum exceeds 280 under temperature, is less than 24 under reductase hours, or exceeds 21.20 under logarithm of count, the supply no longer complies with the requirements for grade A pasteurized milk.

PLANT-PRODUCER INSPECTION RECORD
U.S.P.H.S. FORM 8976 E (FORM 321)

PURPOSE: To provide a permanent record for the inspection of plant producer dairies.

EXPLANATION AND DEFINITIONS: The form is so arranged that each item number corresponds with that on the Milk Plant-Producer Inspection Form, Form 325. This record is arranged to provide space for the recording of the inspection for a period of eighteen (18) months. It is, therefore, easy to determine what progress is made from time to time.

If warning of degrading is necessary and Form 326 is sent, a note to that effect is recorded on the face of this record. If Notice of Degrading, Form 327, is sent, this is recorded on face of the record.

On the section for Milk and Cream Analyses on the back, information is recorded from Report of Analysis of Milk Sample, Form 328.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an inspection is made of a plant-producer dairy and is filed in a special ledger. Ledger sheets should be set up alphabetically by type of establishment, that is, pasteurization plants, producer-distributor dairies and plant-producer dairies.

11-3-47

HEALTH EXAMINATIONS

[illegible]

* Enter the temperature and the reduction hours or the logarithm of the bacterial count in small figures in the upper half of the spaces, and the sum of the last four results in red ink in the lower half thereof. Whenever this sum exceeds 200 under temperature, is less than 22 under reduction hours, or exceeds 18.00 under logarithm of count, the supply no longer complies with the grade A raw milk requirements.

PRODUCER-DISTRIBUTOR INSPECTION RECORD
U.S.P.H.S. FORM 8976 B (FORM 322)

PURPOSE: To provide a permanent inspection record for the inspection of producer-distributor dairies.

EXPLANATION AND DEFINITIONS: The form is so arranged that each item number corresponds with that on the Milk Producer-Distributor Inspection Form, Form 324. This record is arranged to provide space for the recording of inspections for a period of eighteen (18) months. It is, therefore, easy to determine what progress is made from time to time.

If warning of degrading is necessary and Form 326 is sent, a note to that effect is recorded on face of this record. If Notice of Degrading, Form 327, is sent, this is recorded on face of the record.

On the section for Milk and Cream Analyses on the back, information is recorded from Report of Analysis of Milk Sample, Form 328. In the section for health examinations, information from Health Certificate of Milk Handler, Form 329, is recorded.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an inspection is made of a producer-distributor dairy and is filed in a special ledger. Ledger sheets should be set up alphabetically by type of establishment, that is, pasteurization plants, producer-distributor dairies and plant producer dairies.

PASTEURIZATION PLANT INSPECTION FORM
U.S.P.H.S. FORM 8978-C (FORM 323)
SIZE 11" x 8½"

FRONT

Form 8978-C
 FEDERAL SECURITY AGENCY
 PUBLIC HEALTH SERVICE
 Rev. December 1948

**PASTEURIZATION PLANT
 INSPECTION FORM**
(INCLUDING RECEIVING STATIONS)

Budget Bureau No. 68-R090.
 Approval expires 10-31-47.

**GALLONS SOLD DAILY IN
 COMMUNITY**

Whole milk _____
 Buttermilk _____
 Cream _____
 Other milk prod-
 ucts _____
TOTAL _____

(City, county, or district)

NAME _____ **LOCATION** _____
 SIR: An inspection of your plant has this day been made and you are notified of the defects marked below with
 a cross (X). Violation of the same item on two successive inspections calls for immediate degrading.

Item No. 1

- (1) *Floors*.—Smooth finish, no pools (), wall joints and floor surface impervious (), trapped drains, no sewage backflow (), clean and free of litter ()
- (2) *Walls and ceilings*.—Smooth, washable, light-colored finish, good repair (), clean ()
- (3) *Doors and windows*.—In fly season, outer openings with effective screens and self-closing doors, or fly-repellent fans or flaps. ()
- (4a) *Lighting*.—Adequate artificial light evenly distributed (see Code) (), in new plants, window and skylight area 10% of floor area ()
- (4b) *Ventilation*.—No undue condensation and odors. ()
- (5) *Miscellaneous protection from contamination*.—Processes partitioned (), rooms of sufficient size (), raw milk not unloaded directly into pasteurization room (), dump vats covered, ports protected (), flies under control (), no woven-wire strainers, pasteurized milk strained only through perforated metal (), unsterilized raw-milk equipment not used for pasteurized milk (), no raw-milk bypass around pasteurizers (), no direct opening to stables or living quarters (), no drip from mezzanine or overhead pipes (), ingredients properly stored and handled (), no unapproved products handled ()
- (6) *Toilet facilities*.—Comply with plumbing code (), good repair (), clean (), ventilated (), no direct opening (), self-closing doors (), free of flies (), washing sign (), privies, if used, comply item 10r ()
- (7) *Water supply*.—Sufficient outlets (), adequate (), safe, source complies item 11r ()
- (8) *Hand-washing facilities*.—Adequate, convenient () hot and cold water, soap, sanitary towels (), hands washed after toilet ()
- (9) *Sanitary piping*.—Easily cleanable size and length (), smooth uncorroded surfaces (), sanitary fittings, interior surfaces accessible for inspection (), pasteurized products conducted therein ()
- (10) *Construction and repair of containers and equipment*.—Easily cleanable, smooth, noncorroded surfaces (), no open seams (), good repair (), self-draining (), pressure-tight seats on submerged thermometers (), approved single-service containers ()
- (11) *Disposal of wastes*.—In public sewer or as approved by State board of health (), trash and garbage kept in covered containers ()
- (12a) *Cleaning of containers and equipment*.—Containers thoroughly cleaned after each usage (test 10) (), equipment each day ()
- (12b) *Bactericidal treatment of containers and equipment*.—Containers treated (see item 14r for manual methods) after each cleaning to reduce bacterial count to 1 per cc. of capacity (test 11) (), assembled equipment once daily immediately before run, with steam flow 200° F. or hot-water flow 170° F. at outlets for 5 minutes, or approved chlorine solution flow for 2 minutes (test 12); supplementary treatment for equipment not thus reached () (see Code) ()
- (13) *Storage of containers and equipment*.—In clean crates or racks above floor, protected from flies, splash, dust, inverted when practicable. ()
- (14) *Handling of containers and equipment*.—No handling of surfaces to which milk is exposed. ()
- (15) *Storage of caps, etc.*—Caps purchased in tubes, parchment papers, and single-service containers

Item No. 2

- in cartons (), kept therein in cabinet or other clean dry place (), first cap and paper discarded ()
- (16a) * *Specifications for pasteurization thermometers*.—All Code specifications met by all new indicating and recording thermometers, by all replacements, and by recording thermometers under repair which require renewal of tube system (); existing thermometers meet at least accuracy and lag specifications (tests 1, 2, 3, and 13) ()
- (16b) * *Maintenance of pasteurization temperature and time*.—
 (A) *For manual-discharge heated holders*:
Temperature control.—Adequate agitation throughout holding period, agitator sufficiently submerged (); indicating and recording thermometers on each vat throughout pasteurization (); recorder reads no higher than indicator (test 4) (); thermometer bulbs submerged ()
Time control.—Charts show 143° F. for 30 minutes, plus emptying time if cooling begun after outlet valve opened (test 6) (); no milk added after holding begun ()
Charts.—Used only 1 day, preserved 3 months (); must show date, location, daily check against indicating thermometer, amount, grade, and product represented, unusual occurrences, and operator's signature ()
 (B) *For all automatic-discharge holders and unheated manual-discharge holders*:
Temperature control.—Dependable thermostatic control and approved milk-flow stop: no manual switch on milk-pump stops; new stops combined with recorder bulb, but cut-out independent of temperature pen arm; power failure stops forward flow; lag of controller-recorder not over 5 seconds for new, 10 for existing, forward flow stops within 1 second after power cuts out (test 16); flow-diversion valves of approved design (test 8), and bulb not over 18 inches upstream; no bypass around stop bulb (). Cut-in and cut-out at or above 143° F. or 160° F. (tests 14, 15), setting sealed, cut-out infrequent (). No holder-heater permanently connected with water make-up line (). Requirements when flow stop used only upstream from holder: (a) no significant temperature drop in holder (test 17), (b) bulb of pump stop in milk at heated point, (c) no forward gravity flow in stop position, (d) all parts of inlet lines below stop bulb have continuous flow during operation and are self-draining when forward flow stops, (e) no temperature loss due to cold holder metal or contents (test 15) or due to (f) backflow into holder (). Requirements when flow stop used only downstream from holder: (a) holder unheated, (b) flow-diversion device used, and (c) simultaneous temperature difference not over 1° F. (test 18) (). Indicating and recording thermometers at each stop bulb, on each manual-discharge vat and pocket, and at outlet of automatic-discharge system unless each pocket so equipped; bulbs close together (). Recorder reads no higher than indicator (test 4) (). Pasteurization temperature must be shown by charts near flow stops throughout forward flow; by charts on individual vats for 30 minutes, plus filling time if cooling begun before outlet valve opened, or plus filling and emptying times if cooling begun after outlet opened (test 6); by all other charts while milk passes thermometer bulb, otherwise milk repasteurized ()

Date _____, **Inspector** _____

See middle of reverse side for footnotes.

(OVER)

88-13223-3

BACK

Item No. 3 *Time control.*—No milk added to vats or pockets after holding begun (). Maximum speeds of motor and drive for timing devices of automatic batch holders and for milk pumps of tubular holders give adequate holding time (test 19); sealed if speed variable (). No overflow from one pocket to another (). No air or gas accumulates in tubular holders (). Special requirements for 30-minute tubular holders () ()

Charts.—Same as for (A) (); must also show periods of forward flow, and daily check of cut-in and cut-out temperatures () ()

(16c)* *Inlet and outlet valves and connections.*—Any inlet and outlet valves used on single-vat installations must be leak-protector type¹, otherwise piping disconnected (), all multiple-vat installations have leak-protector inlets, also leak-protector outlets except where Code permits disconnecting outlet piping instead (); 30-minute tubular holders have leak-protector outlet or outlet piping disconnected until 30 minutes after filling begun (); leak-protector valves of approved design, effective in all closed positions, and installed in proper position (test 8) (); inlets and outlets below milk level have close-coupled valves (); plug-type valves have approved stops (); top inlets have air relief if submerged (). Valves kept fully closed except inlet while filling and outlet while emptying (); outlet valves sterilized automatically² before opening if not leak protected or if milk accumulates in channel (test 9) () ()

(16d)* *Air heating.*—Air in vats and pockets heated to at least 5° F. above milk temperature during heating and kept at 148° F. or higher during holding, with approved device (), approved trap on steam line (), approved air thermometer (test 7), bulb at least 1 inch above milk () ()

(16e)* *Vat and pocket covers and cover ports.*—No drainage from top of cover into vat, open or closed (), ports surrounded by raised edges (), pipes, thermometers, etc., through cover have aprons un-

Item No. 3 less joint watertight (); covers kept closed () ()

(16f)* *Preheating holders.*—Holders not used as heaters are preheated to pasteurization temperature just before run, also when empty after shutdown exceeding holding period, unless outlet has flow-diversion valve () ()

(17) *Cooling.*—All raw milk and cream cooled to 50° F. on receipt unless to be pasteurized within 2 hours (), pasteurized milk cooled to 50° F. and held thereat until delivery (); header gap on surface coolers not less than ¼ inch or thickness of header at gap (), condensation and leakage from cooler supports and headers, unless completely enclosed in covers, directed away from tubes and milk trough (), recirculated water and refrigerant of required sanitary quality (), cooler covered or in separate room (), cooler shields tight fitting (); pasteurized-milk (or heat-transfer medium) side automatically under greater pressure than raw milk in regenerators at all times (test 20) (see Code) () ()

(18)* *Bottling.*—Mechanical bottler, simple design requiring infrequent adjustment (), properly covered (), float adjustable without lifting cover (), filler pipe and filling valves with condensation diverting apron (), infeed conveyors with overhead shields () ()

(19) *Overflow milk.*—Discarded () ()

(20)* *Capping.*—Mechanical capper integral with bottler requiring infrequent adjustment (), imperfectly capped bottles dumped and repasteurized (), cap protects pouring lip to at least greatest diameter () ()

(21)* *Personnel, health.*—Required examinations and tests (), rejected persons not employed (), no person with infected wound or lesion () ()

(22) *Personnel, cleanliness.*—Clean outer garment, washable for inside employees (), hands clean () ()

(23) *Miscellaneous—Vehicles.*—Clean (), covered (), no contaminating substances transported (); distributor's name shown (). *Surroundings.*—Kept neat and clean () ()

¹ The item numbers correspond to the item numbers for Grade A pasteurized milk in the 1939 edition of the Public Health Service Milk Ordinance and Code, to which please refer.

² Lip-cover caps are not required for Grade B pasteurized. All other Grade B pasteurized requirements (except bacterial count before and after pasteurization) are the same as for Grade A pasteurized.

³ Required for newly installed equipment only. * Items or parts of items not required for receiving stations.

TESTS OF PASTEURIZATION PLANT EQUIPMENT TO BE MADE BY HEALTH DEPARTMENT

(These tests are in addition to equipment requirements for which compliance is determined by inspection)

TEST	WHEN REQUIRED (All periodic tests are also required initially)	SEE 1039 CODE (Item and page)	Tests Made To-day (Y)	IDENTITY OF EQUIPMENT AND RESULTS OF TESTS
All types of pasteurizers:				
1. All indicating thermometers: temperature accuracy.....	Monthly.....	16p(a), p. 99.		
2. All recording thermometers: temperature accuracy.....	Semiannually and when frequent adjustments necessary.	16p(a), p. 100.		
3. All recording thermometers: time accuracy.....	Monthly.....	16p(a), p. 101.		
4. All recording thermometers: temperature ¹ check against indicating thermometer.	Monthly.....	16p(b), pp. 103, 112.		
5. All manual-discharge vats and pockets: emptying (also filling) time where required by Code (see 16b A and B above).	Initially and after any change which may affect these times.	16p(b), pp. 103, 112.		
7. All air-space thermometers: temperature accuracy.	Initially.....	16p(d), p. 127.		
8. All leak-protector inlet, outlet, and diversion valves: Any leakage past seal in any closed position when downstream pipe disconnected?	Plug types initially, poppet types monthly.	16p(c), pp. 106, 117.		
9. All outlet valves: when milk flow stopped, does channel discharge through leak grooves in all closed positions?	Initially.....	16p(c), p. 118.		
10. All soaker bottle washers: percent caustic.....	Monthly.....	12p, p. 95.		
11. Bactericidal treatment of bottles and cans: samples for bacterial count; temperature (or chlorine strength) and time.	Monthly.....	12p, p. 95.		
12. Treatment of assembled equipment: temperature (or chlorine strength) and time (see 12b over).	Monthly.....	12 p. p. 93.		
Additional tests for automatic pasteurizers:				
13. All indicating thermometers on pipe lines: thermometric lag.....	Initially.....	16p(a), p. 99.		
14. All milk-flow stops: milk temperatures at cut-out and cut-in ¹	Monthly.....	16p(b), pp. 105, 111.		
15. All automatically controlled holder heaters: temperature of heating medium at cut-in and cut-out. ²	Monthly.....	16p(b), pp. 106, 111.		
16. All recorder-controllers: thermometric lag ³	Monthly.....	16p(c), p. 107.		
17. All 30-minute holders with upstream flow stops: significant temperature drop.	Initially and when controller seal of automatic holder heater broken.	16p(b), p. 108.		
18. All holders with downstream flow stops: simultaneous temperature difference.	Initially.....	16p(b), p. 111.		
19. All automatic holders: holding time (if satisfactory, seal the setting of variable speed drives and motor governors).	Initially and when seal broken or after change affecting holding time.	16p(b), p. 114.		
20. All non-self-draining milk-to-milk regenerators with pasteurized milk closed to atmosphere: sufficient storage in pasteurized line to maintain milk level for 1 hour during shutdown.	Monthly.....	17p, p. 133.		

¹ Enter on chart. Adjust thermometer if necessary.

² Enter on chart. If necessary, adjust controller setting and reseat.

³ Enter on chart. If necessary, adjust holder heater controller setting and reseat.

⁴ Enter on chart.

16-1523-1

U. S. GOVERNMENT PRINTING OFFICE

PASTEURIZATION PLANT INSPECTION FORM
U.S.P.H.S. FORM 8978-C (FORM 323)

PURPOSE: To provide a uniform inspection sheet for the pasteurization plants.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for the checking of each item in milk sanitation. The finding for each item violated is indicated with an (X). Instructions for the use of this record in connection with the inspection of pasteurization plants are given in the Standard Milk Ordinance.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an official inspection is made of the pasteurization plant. All subsequent or partial inspections are recorded on the Pasteurization Plant Inspection Record, Form 320. Inspection records are filed in individual folders under the name of the owner of the pasteurization plant.

11-3-47

MILK PRODUCER - DISTRIBUTOR INSPECTION FORM - FORM 324
SIZE 11" x 8½"

FRONT

**MILK PRODUCER-DISTRIBUTOR
INSPECTION FORM¹**

**GALLONS SOLD DAILY IN
COMMUNITY**

Grading Period.....

Whole milk.....
 Buttermilk.....
 Cream.....
 Other.....

Present Grade.....

(City, county, or district)

TOTAL.....

NAME.....

LOCATION.....

SIR: An inspection of your dairy has this day been made and you are notified of the defects marked below with a cross (X). Violation of the same item on two successive inspections calls for immediate degrading.

Item No.²

COWS

- (1) *Tuberculosis and other diseases.*—Tuberculin test annually except in modified accredited counties (), annual abortion test effective..... 19.....
 (), certificates of both tests on file (), other tests as required (), no cows with extensive induration of udder (), no cows giving abnormal milk ()

DAIRY BARN

- (2) *Lighting, milking barn.*—Adequate light openings (), adequate artificial light for night milking ()
 (3) *Air space and ventilation.*—Well ventilated (), no overcrowding ()
 (4a) *Floor construction, milking barn.*—Floors and gutters, concrete or other impervious and easily cleaned material in good repair (), graded ()
 (4b) *Floor cleanliness, milking barn.*—No accumulations beyond one milking (), no horses, pigs, fowl, calves, etc. ()
 (5) *Walls and ceilings.*—Painted biennially or white-washed annually or other satisfactory finish (), clean and in good repair (), ceiling tight if feedstuffs over (), feed-room partition dust-tight with door ()
 (6a) *Cow yard, grading and draining.*—Graded (), drained (), no pooled wastes ()
 (6b) *Cow yard, cleanliness.*—Clean (), no swine ()
 (7) *Manure disposal.*—Stored inaccessible to cows and, during fly season: (a) Spread upon fields, or (b) piled not more than 4 days and then spread, or (c) stored not more than 7 days in impervious bin or curbed platform and then spread, or (d) stored in tight, screened, and trapped manure shed, or (e) fly breeding minimized by other approved methods.....

MILK HOUSE

- (8a) *Floors.*—Smooth concrete or other impervious material (), graded to drain ()
 (8b) *Walls and ceilings.*—Smooth dressed lumber, sheet metal, or plasterboard, well painted with washable paint; hollow tile, cement blocks, bricks, concrete, or cement plaster, surfaces and joints smooth.....
 (8c) *Lighting and ventilation.*—Effective window area at least 10 per cent of floor area (), adequate artificial lighting (see Code) (), adequate ventilation (), doors and windows closed during dusty weather ()
 (8d) *Screening.*—All openings effectively screened and doors open outward and self-closing, unless flies otherwise kept out.....
 (8e) *Miscellaneous requirements.*—Used for milk purposes only, except by permission (), milk house operations not conducted elsewhere (), no opening into living quarters or stable (), piped water (), wastes properly disposed of (), processes partitioned (), 2-compartment stationary wash and rinse vats, 3 compartments if chlorine used (), adequate water-heating facilities ()
 (9) *Cleanliness and flies.*—Floors, walls, windows, shelves, tables, and equipment clean (), no trash or unnecessary articles (), all necessary fly-control methods ()

TOILET

- (10) *Toilet.*—Conveniently located (), constructed and operated according to Code (), no evidence of defecation or urination about premises ()

Item No.²

WATER SUPPLY

- (11) *Water supply.*—Easily accessible (), adequate (), no surface or cistern water unless approved (), safe, sanitary quality (see Code) ()

UTENSILS

- (12) *Construction.*—Smooth heavy-gage material (), corrosion-proof surface, no agateware (), easily cleanable shape (), joints soldered flush (), good repair (), no woven-wire cloth (), milk pails small-mouth design (), approved single-service containers ()
 (13) *Cleaning.*—Cleaned after each usage (), must look and feel clean ()
 (14) *Bactericidal treatment.*—Steam cabinet 170° F. for 15 minutes or 200° F. for 5 minutes, or steam jet 1 minute, or immersed in standard chlorine or 170° F. water for 2 minutes, or flow of standard chlorine or 170° F. water at outlet for 5 minutes, or hot-air cabinet 180° F. for 20 minutes (), cabinets have thermometer in coldest zone ()
 (15) *Storage.*—Left in treating chamber until used or stored inverted on racks or in clean crates above floor in milk house (), cotton disks in original package until used ()
 (16) *Handling.*—After bactericidal treatment no handling of surfaces to which milk is exposed.....

MILKING

- (17) *Udders and teats.*—Clean and rinsed with standard chlorine solution at time of milking (), abnormal milk excluded ()
 (18) *Flanks.*—Flanks, bellies, and tails free from visible dirt at time of milking (), brushing completed before milking begun ()
 (19) *Milkers' hands.*—Clean (), rinsed in standard chlorine solution just before milking each cow (), dry while milking (), hand-washing facilities including soap, water, and individual clean towels convenient to milking barn ()
 (20) *Clothing.*—Clean outer garments.....
 (21) *Milk stools.*—Clean, not padded (), stored above floor ()
 (22) *Removal of milk.*—Immediate removal of milk to milk house or straining room (), no straining or pouring in barn ()
 (23) *Cooling.*—Milk cooled immediately after milking completed to 50° F. or less and so maintained until delivery to consumer.....

BOTTLING AND CAPPING

- (24) *Bottling and capping.*—Sanitary bottle filler (), no hand capping (), caps kept in sanitary tubes in clean, dry place until used (), first cap discarded ()

EMPLOYEES

- (25) *Personnel, health.*—Required examinations and tests (), rejected persons not employed (), no person with infected wound or lesion ()

MISCELLANEOUS

- (26) *Vehicles.*—Clean (), permanent top and permanent or roll-down sides and back (), no contaminating substances transported (), distributor's name shown (). *Premises.*—Surroundings kept neat and clean ()

Date.....

Inspector.

¹ Item numbers correspond to item numbers for Grade A raw milk in latest edition of United States Public Health Service Milk Ordinance and Code, to which please refer for interpretation.
² Not required for Grade B raw. All other Grade B raw requirements (except bacterial standard) are the same as for Grade A raw.

MILK PRODUCER - DISTRIBUTOR INSPECTION FORM - FORM 324

PURPOSE: To provide a uniform inspection sheet for the milk producer-distributor dairies.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for the checking of each item in milk sanitation. The finding for each item violated is indicated with an (X). Instructions for the use of this record in connection with the inspection of producer-distributor dairies are given in the Standard Milk Ordinance.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an official inspection of producer-distributor dairy is made. All subsequent or partial inspections are recorded on the Producer-Distributor Inspection Record, Form 322. Inspection records are filed in individual folders under the name of the producer-distributor.

11-3-47

MILK PLANT-PRODUCER INSPECTION FORM - FORM 325
SIZE 11" x 8½"

**MILK PLANT—PRODUCER
INSPECTION FORM**

GALLONS SOLD DAILY TO

Plant

Grading Period.....

Whole milk.....

Skim milk.....

Cream.....

Present Grade.....

(City, county, or district)

TOTAL.....

NAME..... LOCATION.....

SIR: An inspection of your dairy has this day been made and you are notified of the defects marked below with a cross (X). Violation of the same item on two successive inspections calls for immediate degrading.

Item No.¹

COWS

- (1) *Tuberculosis and other diseases.*—Tuberculin test annually except in modified accredited counties (), certificates on file (), other tests as required (), no cows with extensive induration of udder (), no cows giving abnormal milk ()..... ()

DAIRY BARN

- (2) *Lighting, milking barn.*—Adequate light openings (), adequate artificial light for night milking ()..... ()
- (3) *Air space and ventilation.*—Well ventilated (), no overcrowding ()..... ()
- (4a) *Floor construction, milking barn.*—Floors and gutters, concrete, tight wood, or other impervious and easily cleaned material in good repair (), graded ()..... ()
- (4b) *Floor cleanliness, milking barn.*—No accumulations beyond one milking (), no horses, pigs, fowl, calves, etc. ()..... ()
- (5) *Walls and ceilings.*—Painted biennially or white-washed annually or other satisfactory finish (), clean and in good repair (), ceiling tight if feed-stuffs over (), feed-room partition dust-tight with door ()..... ()
- (6a) *Cow yard, grading and draining.*—Graded (), drained (), no pooled wastes ()..... ()
- (6b) *Cow yard, cleanliness.*—Clean (), no swine ()..... ()
- (7) *Manure disposal.*—Stored inaccessible to cows and, during fly season: (a) Spread upon fields, or (b) piled not more than 4 days and then spread, or (c) stored not more than 7 days in impervious bin or curbed platform and then spread, or (d) stored in tight, screened, and trapped manure shed, or (e) fly breeding minimized by other approved methods..... ()

MILK HOUSE

- (8a) *Floors.*—Smooth concrete or other impervious material (), graded to drain ()..... ()
- (8b) *Walls and ceilings.*—Smooth dressed lumber, sheet metal, or plasterboard, well painted with washable paint; hollow tile, cement blocks, bricks, concrete, or cement plaster, surfaces and joints smooth..... ()
- (8c) *Lighting and ventilation.*—Effective window area at least 10 per cent of floor area (), adequate artificial lighting (see Code) (), adequate ventilation (), doors and windows closed during dusty weather ()..... ()
- (8d) *Screening.*—All openings effectively screened and doors open outward and self-closing, unless flies otherwise kept out..... ()
- (8e) *Miscellaneous requirements.*—Used for milk purposes only, except by permission (), milk house operations not conducted elsewhere (), no opening into living quarters or stable (), wastes properly disposed of (), 2-compartment stationary wash and rinse vats (), adequate water-heating facilities ()..... ()
- (9) *Cleanliness and flies.*—Floors, walls, windows, shelves, tables, and equipment clean (), no trash or unnecessary articles (), all necessary fly-control methods ()..... ()

Item No.¹

TOILET

- (10) *Toilet.*—Conveniently located (), constructed and operated according to Code (), no evidence of defecation or urination about premises ()..... ()

WATER SUPPLY

- (11) *Water supply.*—Easily accessible (), adequate (), no surface or cistern water unless approved (), safe, sanitary quality (see Code) ()..... ()

UTENSILS

- (12) *Construction.*—Smooth heavy-gage material (), corrosion-proof surface, no agateware (), easily cleanable shape (), joints soldered flush (), good repair (), no woven-wire cloth (), milk pails small-mouth design ()..... ()
- (13) *Cleaning.*—Cleaned after each usage (), must look and feel clean ()..... ()
- (14) *Bactericidal treatment.*—Steam cabinet 170° F. for 15 minutes or 200° F. for 5 minutes, or steam jet 1 minute, or immersed in standard chlorine or 170° F. water for 2 minutes, or flow of standard chlorine or 170° F. water at outlet for 5 minutes, or hot-air cabinet 180° F. for 20 minutes (), cabinets have thermometer in coldest zone ()..... ()
- (15) *Storage.*—Left in treating chamber until used or stored inverted in protected place in milk house (), cotton disks in original package until used ()..... ()
- (16) *Handling.*—After bactericidal treatment no handling of surfaces to which milk is exposed..... ()

MILKING

- (17) *Udders and teats.*—Clean and rinsed with standard chlorine solution at time of milking (), abnormal milk excluded ()..... ()
- (18) *Flanks.*—Flanks, bellies, and tails free from visible dirt at time of milking (), brushing completed before milking begun ()..... ()
- (19) *Milkers' hands.*—Clean (), rinsed in standard chlorine solution just before milking each cow (), dry while milking (), hand-washing facilities including soap, water, and individual clean towels convenient to milking barn ()..... ()
- (20) *Clothing.*—Clean outer garments..... ()
- (21) *Milk stools.*—Clean, not padded (), stored above floor ()..... ()
- (22) *Removal of milk.*—Immediate removal of milk to milk house or straining room (), no straining or pouring in barn ()..... ()
- (23) *Cooling.*—Milk either delivered to plant, or cooled to 70° F., within 2 hours after milking completed..... ()

MISCELLANEOUS

- (26) *Vehicles.*—Clean (), covered (), no contaminating substances transported (). *Premises.*—Surroundings kept neat and clean ()..... ()

Date....., Inspector.

¹ Item numbers correspond to item numbers for Grade A raw milk (for pasteurization) in latest edition of United States Public Health Service Milk Ordinance and Code, to which please refer for interpretation. The requirements for Grade B raw (for pasteurization) are the same except for the bacterial standard.

MILK PLANT-PRODUCER INSPECTION FORM - FORM 325

PURPOSE: To provide a uniform inspection sheet for the milk plant-producer dairies.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for the checking of each item in milk sanitation. The finding for each item violated is indicated with an (X). Instructions for the use of this record in connection with the inspection of dairies is given in the Standard Milk Ordinance.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an official inspection is made of the dairy. All subsequent or partial inspections are recorded on the Plant-Producer Inspection Record, Form 321. Inspection records are filed in individual folders under the name of the producer.

11-3-47

WARNING OF DEGRADING . FORM 326
SIZE 5" x 7"

Warning of Degrading

Your attention is respectfully called to dairy inspection sheet posted _____ 19____. If violations found checked are not promptly and completely corrected, the output of this dairy or milk plant is subject to degrading. We trust that you will give this matter your immediate attention in order that you may retain your present grade.

Date _____ 19____

Health Officer

HEALTH DEPARTMENT

Inspector

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 326

PURPOSE: To provide a warning to the dairy of degrading in violation of items of sanitation as set out in the requirements of the Milk Ordinance.

EXPLANATION AND DEFINITIONS: Self- explanatory.

USED BY: Health officer and sanitarian.

OFFICE MECHANICS AND FILING: This record is filled in by the sanitarian and approved by the health officer. The permanent record is recorded in the milk ledger.

11-3-47

NOTICE OF DEGRADING - FORM 327
SIZE 5" x 7"

Notice of Degrading

♦♦♦♦♦

Due to violation of grade sheet items on two successive inspections, it has been necessary to DEGRADE the output of your dairy or milk plant to Grade_____effective_____19____. Milk and milk products sold from this dairy must be sold only under grade label given above.

Whenever violated items are corrected, your output may be restored to its former grade. Application for reinspection for purpose of restoring your grade must be made to the health officer in writing. Change of label to a higher grade must be approved by health officer before change is made.

Date_____19____

Health Officer

HEALTH DEPARTMENT

Inspector

Tennessee Department of Public Health No. 327

PURPOSE: To provide a record for the notice of degrading of dairies not complying with the rules and regulations as set out in the ordinance governing the sale of milk and milk products.

EXPLANATION AND DEFINITIONS: Self-explanatory.


USED BY: Sanitarian.

OFFICE MECHANICS AND FILING: This record is filled out by the sanitarian and approved by the health officer. The notice is filed in the ledger sheet under the dairy being degraded.

REPORT OF ANALYSIS OF MILK SAMPLE - FORM 328
 SIZE $3\frac{1}{4}$ " x $5\frac{1}{2}$ "

FRONT

THIS SIDE OF CARD IS FOR ADDRESS



BACK

Dear Sir:

The laboratory analysis of milk sample collected from your _____

_____ on _____ 19____ is as follows:

Official Plate Count _____

Per Cent Butter Fat _____

The temperature at time of collection was _____ ° F.

Note: Report applies only to particular bottle or can from which sample was taken:

Remarks:

DEPARTMENT OF HEALTH

By _____

TENNESSEE DEPARTMENT OF PUBLIC HEALTH NO. 328

REPORT OF ANALYSIS OF MILK SAMPLE - FORM 328

PURPOSE: To provide a record for the notification of official plate count for the producer or distributor whose milk has been collected and examined by the State Laboratory.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Sanitarian.

OFFICE MECHANICS AND FILING: The record is to be filled in by the sanitarian and the information recorded in the milk ledger in the space provided.

11-3-47

HEALTH CERTIFICATE OF MILK HANDLER - FORM 329
SIZE 5" x 5½"

FRONT

HEALTH CERTIFICATE OF MILK HANDLER

_____ Health Department

_____ Tennessee

_____ 19____

_____ Employed at

_____ Dairy has this
day been examined and found free from any communicable disease
transmissible by milk.

Examined by:

Signed:

_____ M.D.

_____ M.D.

Health Officer

This certificate is issued subject to conditions printed on back.

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 329

BACK

NOTICE

1. The certificate must be renewed upon expiration one year from date. It must also be renewed following any attack of or contact with a communicable disease transmissible by milk.
2. The certificate is issued or renewed only after a medical examination has been made, recorded on a standard form, and filed with the Health Department.
3. Employer will be responsible for keeping such a certificate for each person employed and shall obtain a certificate for each new employee before he is permitted to handle milk.
4. Certified employees changing place of employment must notify the Health Department.
5. Attacks of sore throat, diarrhea or dysentery or evidence of other communicable disease must be reported immediately to the Health Department by the milk producer or distributor concerned.
6. No person living in house with a case of typhoid fever, diphtheria or scarlet fever shall be allowed to work in dairy or to handle milk in any establishment where milk is sold.

HEALTH CERTIFICATE OF MILK HANDLER - FORM 329

PURPOSE: This record provides a physical examination certificate for dairy employees.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Health officer and sanitarian.

OFFICE MECHANICS AND FILING: This provides a permanent record of all employees of dairies. The findings are recorded in the milk ledger in the space provided for this information.

11-3-47

RECORD OF EXAMINATION OF MILK HANDLER - FORM 330
SIZE 11" x 8½"

RECORD OF EXAMINATION OF MILK HANDLER

NAME	Age	Sex	Color
ADDRESS			
Date of Examination			
Employed at			
Employer			
Type of Work			
History of:			
Tuberculosis			
Typhoid			
Diphtheria			
Special physical findings indicating presence of communicable disease			
Laboratory Findings:			
Nose & Throat Culture			
Stool Culture			
Urine Culture			
Other Exams.			
Remarks			
Examiner			

RECORD OF EXAMINATION OF MILK HANDLER . FORM 330

PURPOSE: This form is used to provide a record of the physical examination of employees or individuals handling milk or milk products.

EXPLANATION AND DEFINITIONS: This record is filled in by the medical examiner.

USED BY: Health officer, sanitarian and clerk.

OFFICE MECHANICS AND FILING: Record of findings filled out by the medical officer. Filed in individual folder for workers at all dairies.

11-3-47

APPLICATION FOR MILK PERMIT - FORM 331
 SIZE 11" x 8½"

APPLICATION FOR MILK PERMIT

I, _____
(NAME OF MILK PRODUCER OR DISTRIBUTOR)
 operating _____ hereby
(NAME OF BUSINESS)
 make application to _____ Health Department
 for a permit to sell milk and milk products in _____
(TOWN OR CITY)
 Tennessee.

In making this application I understand that permits are issued only after compliance with the requirements of the City Milk Ordinance, and I further understand that continuation of this permit will depend upon my continued observance of the requirements of the City Milk Ordinance in general, and particularly of those parts of the Ordinance requiring the following:

1. Furnishing Health Officer a record of Physical Examination and obtaining a Health Certificate at least annually for each milk handler employed by me.
2. Permitting samples of Milk and Milk Products to be collected routinely by the Health Officer or Milk Inspector.
3. Permitting inspection by the Health Officer or Milk Inspector of any of my premises used in the production or handling of milk at anytime when such production or handling operations are in progress, or at anytime during daylight hours.

Date _____ Signed _____

Address _____

PERMIT NO. _____ Issued _____, 19____

APPLICATION FOR MILK PERMIT • FORM 331

PURPOSE: To provide a record of milk producers and distributors.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: The face of this record is made out by the applicant. This record is to be filed in the producer and distributor's individual folder.

11-3-47

MILK PERMIT - FORM 332
 SIZE 6¼" x 10½"

<p>MILK PERMIT NO. _____</p> <p>ISSUED TO _____</p> <p>Address _____</p> <p>Dairy or Dairy Farm Located _____</p> <p>Date _____ 19____</p>	<div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 10px;"> <h2 style="margin: 0;">MILK PERMIT</h2> </div> <p>No. _____</p> <p style="text-align: center;">_____ HEALTH DEPARTMENT</p> <p style="text-align: center;">_____ <i>Name of Milk Producer or Distributor</i></p> <p style="text-align: center;">_____ <i>Location and Post Office Address</i></p> <p>is hereby granted permission to sell Milk and Milk Products in the City of _____ Tennessee, under and in accordance with the Ordinances of said city and subject to the Rules and Regulations of the Health Department.</p> <p>Issued at _____, Tennessee.</p> <p>This _____ day of _____ 19____</p> <p>Signed _____ <i>Milk Inspector</i> <i>Health Officer</i></p> <p style="font-size: small;">This permit is issued subject to conditions in application and is good until suspended or revoked by the Health Department. It is not transferable and must be kept posted in a conspicuous place on the premises for which it was issued.</p> <p style="text-align: center; font-size: x-small;">TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 332</p>
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PURPOSE: To provide a record of milk producers and distributors in accordance with requirements of the ordinance and subject to rules and regulations of the health department.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Sanitarian

OFFICE MECHANICS AND FILING: This record is filled in by the sanitarian and approved by the health officer. The permanent record is the stub which is detached from the Milk Permit Book.

11-3-47

APPLICATION FOR FOOD PERMIT- FORM 333
SIZE 11" x 8½"

APPLICATION FOR FOOD PERMIT

I, _____
OPERATING _____ (NAME OF ESTABLISHMENT) _____ (LOCATION) HEREBY
MAKE APPLICATION TO _____ (CITY OR COUNTY)
HEALTH DEPARTMENT FOR A PERMIT TO ESTABLISH, MAINTAIN AND/OR OPERATE A _____ (TYPE)
SERVING _____ PERSONS DAILY AT _____ TENNESSEE.
(No. APPROXIMATELY) (MAILING ADDRESS)

IN MAKING THIS APPLICATION, I UNDERSTAND THAT PERMITS ARE ISSUED ONLY AFTER COMPLIANCE WITH THE REQUIREMENTS OF ORDINANCES REGULATING THE SALE OF FOOD AND/OR DRINK. I FURTHER UNDERSTAND THAT CONTINUATION OF THIS PERMIT WILL DEPEND UPON MY CONTINUED OBSERVANCE OF THE REQUIREMENTS OF THE ORDINANCES AND PARTICULARLY OF THOSE PARTS OF THE ORDINANCE REQUIRING THE FOLLOWING:

1. PERMIT SUCH LABORATORY OR PHYSICAL EXAMINATIONS TO BE MADE AS ARE CONSIDERED NECESSARY BY THE HEALTH OFFICER OR HIS REPRESENTATIVE.

2. PERMIT INSPECTION BY THE HEALTH OFFICER OR HIS REPRESENTATIVE OF ANY OF THE PREMISES USED IN THE DISPENSING OR HANDLING OF FOOD AND DRINK AT ANY TIME WHEN SUCH DISPENSING OR HANDLING OPERATIONS ARE IN PROGRESS; AND SUBJECT TO EMERGENCIES THE HEALTH OFFICER SHALL HAVE ACCESS TO SAID PREMISES AT ALL TIME.

3. CORRECT ANY VIOLATIONS OF SAID ORDINANCES WHICH THE HEALTH OFFICER MAY FIND, AND MAKE SAID CORRECTIONS PROMPTLY.

SIGNED _____

ADDRESS _____

DATE _____

(Do NOT WRITE BELOW THIS LINE)

PERMIT No. _____ DATE ISSUED _____

APPLICATION FOR FOOD PERMIT . FORM 333

PURPOSE: To provide a record of food handling establishments in accordance with requirements of the ordinance and subject to rules and regulations of the health department.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Food handling establishment, sanitarian and clerk.

OFFICE MECHANICS AND FILING: The face of this record is made out by the applicant. This record is to be filed in the individual folder of the food handling establishment.

9-20-48

FOOD PERMIT - FORM 334
SIZE 6½" x 11"

Food Permit No. _____ _____ (Owner and/or operator) _____ (Location) _____ (Postoffice Address) _____ (Type) Date _____ 19____	<div style="border: 2px solid black; padding: 10px;"> <p>NO. _____ FOOD PERMIT</p> <p style="text-align: right;">HEALTH DEPARTMENT</p> <p>_____</p> <p style="text-align: center;">(Owner and/or operator)</p> <p>_____</p> <p style="text-align: center;">(Location and Postoffice Address)</p> <p>Is hereby granted permission to establish, maintain, and operate a</p> <p>_____ in _____</p> <p style="text-align: center;">(Type) (City or County)</p> <p>Tennessee, under and in accordance with the ordinance of said City and/or County and subject to the Rules and Regulations of the Health Department.</p> <p>Issued at _____, Tennessee.</p> <p>This _____ day of _____ 19____</p> <p>Signed _____</p> <p style="text-align: center;">Sanitarian Health Officer</p> <p><small>This permit is issued subject to conditions in application and is good until suspended or revoked by the Health Department. It is not transferable and must be framed and kept posted in a conspicuous place on the premises for which it was issued.</small></p> </div>
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Tennessee Department of Public Health—Form 334

PURPOSE: To issue a permit to food handling establishments in accordance with requirements of the ordinance and subject to rules and regulations of the health department.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Food handling establishment, health officer and sanitarian.

OFFICE MECHANICS AND FILING: This permit is filled in by the sanitarian and approved by the health officer. The permanent record for the health department is the stub which is detached from the Food Permit Book.

9-20-48

Pages 335-337 missing

EATING AND DRINKING ESTABLISHMENT INSPECTION RECORD
U.S.P.H.S. FORM 8976-F (FORM 338)

PURPOSE: To provide a permanent inspection record for the eating and drinking establishments in which the Standard Food Ordinance is in force.

EXPLANATION AND DEFINITIONS: The form is so arranged that each item number corresponds with that on the Inspection Form For Eating and Drinking Establishments, Form 339. This record is arranged to provide space for the recording of inspections for a period of eighteen (18) months. It is, therefore, easy to determine what progress is made from time to time.

The back of the record is so arranged to record the findings made on examination of utensils and other tests such as bactericidal treatment, chlorine strength at the time of test, refrigerator temperature and water analyses. Also there is space for information pertinent to examination of the employees if required.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This form is used each time an inspection is made of eating and drinking establishments, and is filed alphabetically in a ledger by name of establishment.

11-3-47

INSPECTION FORM FOR EATING AND DRINKING ESTABLISHMENTS
U.S.P.H.S. FORM 8967 (FORM 339)
SIZE 11" x 8½"

Form 8967
 FEDERAL SECURITY AGENCY
 PUBLIC HEALTH SERVICE
 (Rev. Dec. 1944)

**INSPECTION FORM FOR
 EATING and DRINKING
 ESTABLISHMENTS**

Budget Bureau No. 68-R082.1
 Expiration date 10-31-47.

Source
 Milk, cream _____
 Cream-filled pastries _____
 Meats _____
 Shellfish _____

(City, county, or district)

Type _____
Number served _____
daily _____
Any kitchen maintained _____
elsewhere? _____

NAME _____ **ADDRESS** _____

Sir: An inspection of your premises has this day been made, and you are notified of the defects marked below with a cross (x). Violation of the same item on two successive inspections requires immediate degrading¹ or suspension of permit. All menu cards or boards shall display grade² _____ notice.

Item No.

- (1) Floors.—Easily cleanable construction, smooth, good repair (); clean (); cleaned only after closing or between meals (), by dustless methods ()
- (2) Walls and ceilings.—All: clean, good repair (); kitchen: light color (), walls smooth, washable to level of splash ()
- (3) Doors and windows.—Outer openings with effective screens and outward-opening, self-closing doors, or fly-repellent fans, or flies absent ()
- (4) Lighting.—Natural or artificial light equivalent to 10 foot-candles on working surfaces (except in dining room), 4 in storage rooms ()
- (5) Ventilation.—All rooms (except cold storage) reasonably free of odors and condensation ()
- (6) Toilet facilities.—Comply with plumbing code (); adequate, conveniently located for employees (); good repair, clean, no flies (); well lighted, outside ventilation (); in new establishments, no direct opening (); self-closing doors (); washing sign for employees (); privies, if used, comply State standards ()
- (7) Water supply.—Running water accessible as required (); supply adequate (); safe, complies State standards ()
- (8) Lavatory facilities.—Adequate, convenient (); hot and cold running water (); soap (); approved sanitary towels (); hands washed after toilet ()
- (9) Construction of utensils and equipment.—Easily cleanable construction, self-draining, no corrosion (); good repair, no open seams, no chipped or cracked dishes (); no cadmium or lead utensils ()
- (10a) Cleaning of equipment.—Clean cases, counters, shelves, tables, meat blocks, refrigerators, stoves, hoods (); clean cloths used by employees ()
- (10b) Cleaning of utensils.—Single-service cups, plates, straws, caps used only once (); eating and drinking utensils thoroughly cleaned after each use (); other utensils cleaned each day (); suitable detergent used (); no cyanide or other poisonous compounds ()
- (10c) Bactericidal treatment of eating and cooking utensils.—Approved bactericidal treatment after cleaning: Immersed 2 minutes in 170° F. water, or one-half minute in boiling water, or 2 minutes in approved chlorine rinse; or kept in steam cabinet 15 minutes at 170° F. or 5 minutes at 200° F.; or in hot-air cabinet 20 minutes at 180° F. (); cabinets have thermometer in coldest zone (); large utensils adequately treated with live steam, boiling water, or chlorine spray or swab (); dish-washing machine properly operated (). Utensils comply bacterial standard (); drying cloths, if used, kept clean and used for no other purpose ()

Item No.

- (11) Storage and handling of utensils.—Stored above floor in clean place protected from flies, splash, dust, etc., inverted or covered when practicable (); no handling of contact surfaces (); single-service cups, straws, etc., purchased in sanitary cartons, kept in clean dry place, and properly handled (); dispensing spoons, dippers kept in hot or running water ()
- (12) Disposal of wastes.—Liquid wastes into public sewer or as approved by State (); no back-siphonage into water supply from toilets, washing machines, sinks, etc. (); garbage stored in tight, non-absorbent, washable receptacles, covered pending removal (), removed frequently and receptacles washed to prevent nuisance ()
- (13) Refrigeration.—Readily perishable foods (including cream-filled pastry, meats, milk, etc.—see Code) stored at 50° F. or less (); ice stored and handled in approved manner (); drip enters open trapped drain or pan ()
- (14a) Wholesomeness of food.—Wholesome, clean, no spoilage (); prepared so safe for human consumption (); cream-filled pastry rebaked unless filling adequately cooked, and promptly cooled ()
- (14b) Wholesomeness of milk products.—Milk, fluid milk products, frozen desserts from approved sources (); milk, etc., served in original individual bottles or from approved bulk dispenser ()
- (14c) Wholesomeness of shellfish.—Shellfish from approved sources (); shucked shellfish kept in original containers ()
- (15a) Storage of food and drink.—No contamination by overhead leakage or submerging (); not on floors subject to flooding from sewage backflow ()
- (15b) Display and serving of food and drink.—Minimum manual contact with food and drink (); no open displays (); no animals or fowls (); flies, roaches, and rodents under control (); no uncolored poisonous insecticides or raticides ()
- (15c) Ratproofing.—Structure ratproofed ()
- (16) Cleanliness of employees.—Clean outer garments, used for no other purpose (); hands clean (); no spitting, no tobacco used where food prepared ()
- (17) Miscellaneous.—Premises kept neat and clean (); no operations in living or sleeping rooms (); clean, adequate lockers for employees' clothing, not in kitchen (); soiled linens, coats, aprons kept in containers ()
- (Sec. 9) Disease control.—No person at work with any communicable disease, sores, or infected wounds (); Section 9 posted in all toilets (); employees' health certificates (if required locally) ()

REMARKS: _____

Date _____

NOTICE.—This report shall not be defaced or removed except by the health officer or his representative.

Inspector. _____

¹ Applicable only where grading ordinance is in effect. For violation of item 1, 2, 4, 5, or 17 degrade to grade B; for all other items to grade C.
² The item numbers correspond to those for grade A in 1943 U. S. Public Health Service Restaurant Ordinance. For "titner restaurant" requirements see Code.
 For sale by Superintendent of Documents, Washington 25, D. C. Price 35 cents per pad of 100. 16-54399-2 GPO

INSPECTION FORM FOR EATING AND DRINKING ESTABLISHMENTS
U.S.P.H.S. FORM 8967 (FORM 339)

PURPOSE: To provide a uniform inspection sheet for eating and drinking establishments.

EXPLANATION AND DEFINITIONS: The form is so arranged as to provide space for the checking of each item in food sanitation. The finding for each item violated is indicated with an (X). Instructions for the use of this record in connection with the inspection of eating and drinking establishments are given in the Standard Food Ordinance.

USED BY: Sanitarian and clerk.

OFFICE MECHANICS AND FILING: This record form is used each time an official inspection is made of the eating and drinking establishment. All subsequent or partial inspections are recorded on the Eating and Drinking Establishment Inspection Record, Form 338. Inspection records are filed in individual folders under the name of the owner of the establishment.

11-3-47

Result:

[illegible][illegible]

Tennessee Department Public Health No. 400.

EXPLANATION AND DEFINITIONS:

Marital Status: (S M W D): The applicable letter is to be encircled.

Referred by: Source of report of case to health department is to be recorded here. "Neighbor," "Physician," "Self," "Nurse," etc.

Para: This refers to number of previous deliveries. Thus for first pregnancy it is designated by "0", and for the woman who has had one pregnancy it is 1, etc.

Date First Visit: On this line the dates patient first sees physician, dentist and nurse are to be entered. This does not call for the names of the physician, dentist or nurse.

Significant Clinical Findings: This refers to such facts in the history or in present condition of the case as the attending physician deems it necessary to furnish to the nurse for her guidance. This space is distinctly not intended for entry of irrelevant details and is to be left blank if there are no significant data.

History of Previous Pregnancies: There should be given only a brief outline of facts likely to have bearing on this pregnancy. For example, "Four pregnancies - convulsions with second - others normal." If previously carried by nursing service, briefly summarize significant parts from old record, giving quantity of medical, dental, and nursing service received, something of results of teaching, etc.

Physician's Orders: Self-explanatory.

Blood Pressure and Urinalysis: Self-explanatory.

Other Laboratory Tests: Include Wassermann, malaria smear, sputum examinations, etc.

Delivery: Summary of facts regarding delivery are to be filled in when the information is obtained. The clerk checks for report of birth and fills in the date the certificate was filed.

Record of Visits: In this section the nurse gives her findings regarding the patient's condition. With the exception of temperature, pulse, visit reported to physician and number of visits to physician, the findings are shown by code.

Visit Reported to Physician: Answered "Yes" or "No."

Number of Visits to Physician: This shows the amount of medical supervision the case is receiving. The number recorded at each nursing visit represents the number of times the patient has been seen by the physician in charge since the last visit. At the first visit the nurse records all visits to physicians which have been made during present pregnancy.

USED BY: Nurse and clerk.

OFFICE MECHANICS AND FILING: This record is to be opened by the nurse at the time of the first visit to maternity case. The record is indexed by the clerk and filed in the family folder. When it is necessary to close this case a summary is made on the inside of the family folder and the record is filed in the closed maternity file. The old record may be summarized on the new one if the person is carried for a second pregnancy.

Page 401 missing

REPORT OF NURSING VISIT TO MATERNITY CASE - FORM 402
SIZE 8½" x 11"

REPORT OF NURSING VISIT TO MATERNITY CASE

DR. _____

ADDRESS _____

PATIENT _____ AGE _____

ADDRESS _____

TEMPERATURE _____ PULSE _____ BLOOD TEST: DATE _____ RESULTS _____

BLOOD PRESSURE: THIS VISIT _____ BLOOD PRESSURE: LAST VISIT _____ DATE _____

REPORT OF TEST FOR ALBUMEN IN URINE _____

OBSERVATION OF PATIENT'S CONDITION _____

ADVICE GIVEN _____

DATE OF VISIT _____ SIGNATURE _____

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - FORM 402

PURPOSE: To inform the doctor of the nurse's findings and advice.

EXPLANATION AND DEFINITIONS: Headings are self-explanatory.

USED BY: Private physician, nurse, and clerk.

OFFICE MECHANICS AND FILING: The nurse prepares this report, and the clerk is responsible for mailing it to the physician.

11-3-47

Pages 403-404 missing

MIDWIFE RECORD - FORM 405

PURPOSE: To provide a current register of persons actively practicing midwifery in the area.

EXPLANATION AND DEFINITIONS: The items pertaining to identification, education and bag equipment are self-explanatory. If physical examinations are done, the findings are to be summarized in the designated space. The item concerning treatment for syphilis should indicate the status of the patient.

The items *Birth Certificates Received* and *Meetings or Classes Attended* provide space for tabulation by year and month.

Silver Nitrate Dispensed to Midwife provides a space for recording the number of packages (boxes containing 4 ampules) dispensed.

Deliveries Since Last Visit (on back of record) - In this space should be recorded the number of deliveries which the midwife reports verbally and not the number of certificates which have been filed.

Condition of Midwife Bag - The condition of the midwife bag is to be coded: 0 - Satisfactory, 1 - Slightly unsatisfactory, etc.

OFFICE MECHANICS AND FILING: The record is made out by nurse when midwife is first seen. It is filed by the clerk, and additional data are added by the nurse and clerk as indicated. The number of deliveries reported by the midwife is checked against the number of certificates received and an attempt made to secure certificates for all unregistered births.

11-3-47

Pages 406-407 missing

Code: e—satisfactory; 1, 2, 3—slightly, moderately or markedly unsatisfactory; x—needing attention; oo—correction

BACK

[illegible]

PURPOSE: For record of periodic medical examination and service to infants, preschool and school children, and adults, and for record of continuing nursing service to these individuals.

EXPLANATION AND DEFINITIONS:

Date Indexed: The date on which the clerk makes the Index Card is entered here.

Birthplace: For persons born in Tennessee this refers to the county, for persons born outside of Tennessee this refers to the State.

Supplemental Facts: Facts in past life (communicable diseases, illnesses, operations, diet, habits, etc.) which are important enough to influence the handling of the case are recorded here. The use of the space is thus left to the discretion of the physician and the nurse using the record.

Immunity Status: The clerk records vaccination and inoculations for which there are data on file in the health department. Information regarding vaccination and inoculations given by private physicians may be recorded with "P.P" and date. The column under "Smallpox" is divided so as to provide space in the upper triangle for record of the date of the vaccination and in the lower triangle for the result. If the child has a scar of smallpox vaccination but the date of vaccination is not known, the word "scar" is written in the lower triangle at top of "Smallpox" column.

Other Tests: Record here Schick and tuberculin tests, Wassermann examinations, etc.

Grade and School: When an infant, preschool child, or an adult is examined, the school or the health center where the examination is made is entered, and "Inf.", "Pres.", or "Adult" is entered instead of the grade. If a school child is examined the school and the grade are entered.

Recording of Examination Findings: This section is so arranged as to provide a double triangle block for notation of findings in code. In the space on the same line the clinician may wish to explain the findings in the space provided following the block. The upper triangle carries the findings in code, and the lower triangle carries the correction in code. The spaces by vision and hearing are to be used to record the vision and hearing acuity. If these findings are not normal the actual findings are recorded; for example, the nurse may note "R 20/30, L 20/40" in the space by vision, and the examining physician would classify such a defect by code. A child wearing glasses at the time of the examination should have vision tested and recorded, with glasses and without glasses.

When "X" is used in coding findings in a physical examination, it indicates a correctable defect which should receive treatment leading to its removal or to a maximum improvement. This implies that conditions marked with 1, 2, or 3, without X are temporary in character or are of such a nature as not to be amenable to further improvement. Thus, following *orthopedic* the examining physician might record a "3" with "congenital amputation of the rt hand," which would mean that it is a markedly unsatisfactory condition but one which is not amenable to treatment. Similarly, after *nose* he might record a "2" with "sub-acute rhinitis" which would mean a moderately unsatisfactory condition but such as not to require treatment because of its temporary nature. On the other hand, the use of X indicates in the opinion of the examining physician that the defect requires the attention of a physician or a dentist.

Parent Present: To be answered "father," "mother," or other relative.

Height-Weight Record: These headings are self-explanatory.

Inspections: This space is provided to give date and findings of inspections which are to be coded as in regular examinations.

Notes on Clinical, Conference, and Filed Visits: This space provides for entries of two sorts: (1) summaries of special records (as crippled children and communicable diseases) and (2) progress notes recording nursing visits, office visits to health department or private physician, laboratory findings, etc.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: This record is to be filled out at the time of first contact with the individual. If this first contact is by nurse (and before a medical examination has been made) she makes entry of identification data and notes. If the health department physician sees the individual first, he makes record as indicated above and records an examination. All subsequent visits and examinations (except for communicable diseases and crippled children's service) are entered on this record. Communicable diseases and crippled children visits are recorded on the forms for these services and when such cases are released, a summary is made and entered on the health record. The record once opened is indexed and filed in the family folder, general preschool or respective school folder.

11-3-47

* Record for each visit with patient, informal

1. Symptoms, complaint, Tpr., ambulatory or bed-ridden
2. Nursing care given, treatments, occupational therapy, diet
3. Transmission or interpretation to family
4. Who gives pt. care? What other plan would be more advisable?
5. Economic problems. Was solution possible? If not, why?
6. Emotional problems of patient or family. Was solution possible? If not, why?

Pages 409-412 missing

FAMILY HEALTH RECORD - FORM 413
SIZE 10" x 8"

FRONT

[illegible]

BACK

[illegible]

PURPOSE: Since the fundamental objective of public health nursing is family service, this record is worked out to facilitate the nurse's function as a family health worker. This form is not exclusively a nursing record; it may be used by any or all of the staff members. This record may be used to record public health services to a family as a group, and to individual members of a family group.

EXPLANATION AND DEFINITIONS:

Surname - Husband's Name: Self-explanatory. (Please state if deceased.)

Wife's Full Maiden Name: Self-explanatory. (Please state if deceased.)

Pertinent Facts Regarding Health Problem In Family: Record here facts in the family history, as tuberculosis, syphilis, diabetes, cancer, mental illness, rheumatic fever, etc., and any other information pertinent to handling the health problems in the family.

Name of Individual: This space will be used only when an individual service is rendered. The name of the individual to whom the service is rendered will be recorded here. This makes it easy for the worker to pick out previous notes on service to individuals and also saves confusion in coding the visit.

Visits: The following will serve as examples of types of service that may be recorded on the family health record as group service:

1. Information about the family's food supply; such as garden, canning, milk, etc.
2. Regular schedule in home life, particularly for eating.
3. Cleanliness in the home, screening, sanitary water supply, and waste disposal.
4. Care of teeth of members of the family - in the home and by the dentist.
5. Regular school attendance for all children.
6. Protection for the family through immunizations.
7. Reaction of family to other members of the family. Kind of cooperation which family exhibits to health worker.
8. Household contacts to tuberculosis cases. (When an individual moves out of the household; if there is a problem with this individual, he should be carried on an individual record.)

The following will serve as examples of types of service that may be recorded on the family health record as individual service. Notation should be made on record indicating type of service rendered and precede notes as: *Tbc.*, *Com. Dis.*, and *O.V.* (Office Visit).

1. Minor communicable diseases, as measles, mumps, whooping cough, and chicken-pox.
2. A member of the family group is ill and individual service is rendered but a return visit is not indicated; as child with otitis media, cold, abrasion which was dressed, etc.

Individual records will continue to be used for major communicable diseases, tuberculosis, maternity, venereal diseases, infants, tumor clinic patients, crippled children, school children referred from teacher's classroom work-sheets needing further service, and others needing individual service.

Plan for Next Visit: To provide space for brief notes; items or subjects to be included in the next visit.

USED BY: Health officer, nurse, sanitarian, nutritionist, and clerk.

OFFICE MECHANICS AND FILING: This record is to be opened on families for which general health services are to be rendered to the family as a group. Individual service on certain types of individuals may also be recorded on this record. (See instructions under visits.)

When this family health record is opened, it is indexed on the usual index card, Form 3, in the name of the head of the family and filed with other index cards. The family health record is kept with the family folder, Form 500. When the family folder is closed, the family health record is filed behind the family folder in the closed family folder file.

In most instances, the service recorded on this record will be group service and coded under (H). When a visit is made to an individual, this will be coded under the specific service rendered.

COMMENT: In order to reduce the volume of notes to be read, it is suggested that this record be summarized at the time the box check is made. The summary should be blocked off by red lines and should contain a brief resume of service in the past and plans for future care.

Example of summary: December, 1948. The S family has moved twice during the past year, but are now living with Mr. S's parents in Russellville temporarily. Mrs. S. is an inactive case of tuberculosis; last examination, 10/48; apparently well. Mr. S. works regularly in a furniture factory, has never had chest x-ray. Future plans: Mrs. S; Mary, age 17; and John, age 15, need chest x-rays. Special attention to diets of entire family.

Pages 414 missing

CLASSROOM WORK SHEET - FORM 415

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE
SIZE 11" x 8½"

FRONT

CLASSROOM WORK SHEET

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE

CHILD'S NAME _____ TEACHER _____

SCHOOL _____ GRADE _____ DATE _____

APPARENT SIGNS OF ABNORMAL CONDITIONS

GENERAL CONDITION AND APPEARANCE	<input type="checkbox"/> VERY THIN	<input type="checkbox"/> LOWERED VITALITY
	<input type="checkbox"/> VERY FAT	<input type="checkbox"/> IRRITABLE
	<input type="checkbox"/> POOR APPETITE	<input type="checkbox"/> EASILY TIRED
	<input type="checkbox"/> POOR FOOD HABITS	<input type="checkbox"/> USES LAVATORY FREQUENTLY
	<input type="checkbox"/> PALE OR SALLOW SKIN	<input type="checkbox"/> PERSISTANT NERVOUS HABITS, AS BITING NAILS AND LIPS
	<input type="checkbox"/> BAD POSTURE	<input type="checkbox"/> CRIPPLING CONDITION
	<input type="checkbox"/> HEIGHT _____ WEIGHT _____ DATE _____	<input type="checkbox"/> POOR ADJUSTMENT TO SCHOOL
	<input type="checkbox"/> AVERAGE WEIGHT _____	

EYES	<input type="checkbox"/> VISION TEST - RIGHT _____ LEFT _____	<input type="checkbox"/> RUBS EYES - EYES INFLAMED
	<input type="checkbox"/> STYES	<input type="checkbox"/> SQUINTS AT BOOK OR BLACKBOARD
	<input type="checkbox"/> CROSS EYES	<input type="checkbox"/> HEADACHES
	<input type="checkbox"/> HOLDS BOOK CLOSE	<input type="checkbox"/> COMPLAINS OF BLURRING OF WORDS

EARS	<input type="checkbox"/> HEARING TEST - RIGHT _____ LEFT _____	<input type="checkbox"/> DIFFICULTY IN UNDERSTANDING THE SPOKEN WORD
	<input type="checkbox"/> EAR DISCHARGE - COTTON IN EARS	<input type="checkbox"/> ATTACKS OF EARACHE
	<input type="checkbox"/> INATTENTION	

SPEECH	<input type="checkbox"/> STUTTERING	<input type="checkbox"/> SOUND SUBSTITUTION (LISPING)
	<input type="checkbox"/> DELAYED SPEECH (BABY TALK)	<input type="checkbox"/> CLEFT PALATE

NOSE AND THROAT	<input type="checkbox"/> FREQUENT ABSENCE FROM SCHOOL DUE TO COLDS	<input type="checkbox"/> MOUTH BREATHING
	<input type="checkbox"/> CHRONIC NASAL DISCHARGE	<input type="checkbox"/> FREQUENT SORE THROAT
		<input type="checkbox"/> ENLARGED NECK GLANDS

TEETH AND MOUTH THE "DENTAL REPORT CARD," FORM 476, OBTAINED FROM LOCAL HEALTH DEPARTMENTS SHOULD BE
USED TO OBTAIN INFORMATION IN REGARD TO DENTAL HEALTH.

TEACHER'S REMARKS OR ADDITIONAL INFORMATION: _____

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES ☐ NO ☐ SPECIALIST RENDERING SERVICE _____

REMARKS BY TEACHER: _____

BACK

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES () NO (). SPECIALIST PENDING SERVICE _____

REMARKS BY TEACHER: _____

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES () NO (). SPECIALIST RENDERING SERVICE _____

REMARKS BY TEACHER: _____

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES () NO (). SPECIALIST RENDERING SERVICE _____

REMARKS BY TEACHER: _____

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES () NO (). SPECIALIST RENDERING SERVICE _____

REMARKS BY TEACHER: _____

FINDINGS AND RECOMMENDATIONS: _____

DATE _____ SIGNATURE _____ AGENCY _____

RECOMMENDATIONS CARRIED OUT: YES () NO (). SPECIALIST RENDERING SERVICE _____

REMARKS BY TEACHER: _____

CLASSROOM WORK SHEET - FORM 415

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE

PURPOSE: To assist the teacher in observing deviations from normal and aid her in screening children who, in her opinion, need special attention.

EXPLANATION AND DEFINITIONS: This form is used by the teacher for referring children to the doctor, nurse, supervisor, attendance teacher, and consultants in special education. The teacher, because of her daily contact with the child, is in an excellent position to observe deviations from normal. However, if she is to assume her role, ways and means should be devised to bring her into closer rapport with other workers concerned with the health of the child. This form is intended to meet this need.

USED BY: Teachers, physicians, nurses, supervisors, attendance teachers, and consultants in special education.

HOW USED: Six of these work sheets, and a supply of Dental Report Cards, Form 476, are included in each teacher's kit which is prepared by the health department and distributed at the first teacher's meeting. The use of these forms should be explained at this meeting either by the supervisor or a nurse. If a nurse is not available, the county or city supervisor should assume the responsibility.

The teacher fills out this form for the children who, in her opinion, are in need of special attention. Also, this form may be filled out following a conference with the physician, nurse, supervisor, attendance teacher, or consultant in special education.

IMMEDIATE STEPS MAY BE TAKEN BY:

1. Notifying the parent of condition found, Form 416.
2. Inviting the parent to come to the school for a conference.
3. Visiting in the home by teacher, nurse, supervisor, attendance teacher, or consultant.
4. Asking the parent to take the child to the health department for a conference with the physician or nurse.

The principal, teacher, parent, physician, nurse, consultant, supervisor, attendance teacher, and person from other allied agency may all need to work together before the desired results are obtained.

By use of the Classroom Work Sheet, Form 415, the child with a health problem is easily located; attention to his problem is more thorough; the advice given is more soundly conceived; medical care, if needed, is achieved earlier; the road to correction is more clearly marked; and the chances of getting lost on the way are lessened.

OFFICE MECHANICS AND FILING: This work sheet is devised primarily for the teacher's use, and should be left in her possession. The health record, Form 408, is used by the health department personnel for continuous service to these individuals. A notation can be made on the school roster, Form 420, under "Other Data", opposite the child's name for a quick reference of the children who have been specially referred.

At the close of the school year the teacher completes the form and transcribes the data to the child's cumulative record. The work sheet is then filed with the cumulative record for the teacher's information for the following year.

CHILD HEALTH SERVICE - FORM 416

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE
SIZE 8½" x 11"

CHILD HEALTH SERVICE

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE

DEAR PARENT:

YOUR CHILD'S HEALTH IS AS IMPORTANT AS HIS PROGRESS IN SCHOOL. IN
THE ROUTINE _____ OF _____
(FULL NAME)
IT WAS FOUND THAT _____

THIS CONDITION SHOULD RECEIVE PROMPT ATTENTION BY _____

DATE _____ SIGNATURE _____

TO THE PHYSICIAN:

THE HEALTH DEPARTMENT AND SCHOOL WOULD APPRECIATE KNOWING YOUR
DECISION IN REGARD TO THE CONDITION NOTED ON THIS SLIP IN ORDER TO COOPERATE
WITH YOU AND THE PARENT IN THE BEST INTEREST OF THE CHILD.

PHYSICIAN'S TREATMENT AND RECOMMENDATIONS: _____

NO FURTHER TREATMENT INDICATED () TREATMENT INCOMPLETE ()

I WISH TO SEE CHILD AGAIN ON _____ 194 _____

DATE _____ SIGNATURE _____ M.D.

THIS REPORT IS TO BE RETURNED TO THE SCHOOL OR HEALTH CHAIRMAN BY THE PARENT
OR CHILD.

CHILD HEALTH SERVICE - FORM 416

COOPERATIVE PROGRAM
OF
EDUCATION - HEALTH - WELFARE

PURPOSE: To provide a written statement for the parents of the findings in child health conferences and routine school examinations by the school physician, or inspections by the nurse. It also provides space for the physician to record his treatment and recommendations.

EXPLANATION AND DEFINITIONS: This form is used by the school physician, private physician and nurse whenever any deviation from normal is noted which in their opinion needs medical attention. This form is taken to the physician at the time the parent takes the child for treatment or recommendations. It should be returned to the health chairman or school after remedial defects have been corrected or recommendations carried out.

USED BY: School physician, private physician, nurse and teacher.

11-3-47

Pages 417-419 missing

SCHOOL ROSTER - FORM 420
SIZE 11" x 8½"

[illegible]

PURPOSE: To furnish the health department a roster of the pupils in the school so that existing records may be assembled and made available at the time school services are rendered.

EXPLANATION AND DEFINITIONS: The space under "Other Data" is for additional information that may be desired.

The other items are self-explanatory.

USED BY: Teacher, health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: The teacher records the names, identifying data and the presence or absence of a smallpox scar on the record and transmits it to the health department. From this roster, the clerk compiles a school file including all existing health records in the health department. Records for pupils not attending school are removed. When this work is completed this roster is placed in the back of the school file where it remains for the rest of the school year. This information may be useful to the nurse and medical officer in rendering school services. The record may be destroyed at the end of the school year.

Page 421 missing

REFERRAL FORM - FORM 422
size 5" x 8"

REFERRAL FORM								
NAME					IF MARRIED WOMAN, MAIDEN NAME			
LAST		FIRST	MIDDLE					
IF CHILD: FATHER		MOTHER		IF MARRIED WOMAN, HUSBAND'S NAME				
NEWBORN: BIRTH	DATE OF	WEEKS OF	BIRTH	COLOR	SEX	AGE	IF ANTEPARTUM, EXPECTED CONFINEMENT DATE	
		GESTATION	WEIGHT					
ADDRESS			COMMUNITY		COUNTY			
DIRECTIONS								
PRIVATE PHYSICIAN				CLINIC				
REASON FOR REFERRING								
HOW REFERRED	PRIVATE PHYSICIAN.....		<input type="checkbox"/>	TELEPHONE.....		<input type="checkbox"/>	BIRTH CERTIFICATE.....	<input type="checkbox"/>
	HOSPITAL (NAME).....		<input type="checkbox"/>	OFFICE CALL.....		<input type="checkbox"/>	DEATH CERTIFICATE.....	<input type="checkbox"/>
	FAMILY.....		<input type="checkbox"/>	OTHER (EXPLAIN).....		<input type="checkbox"/>	STILLBIRTH CERTIFICATE.....	<input type="checkbox"/>
	OTHER (EXPLAIN).....		<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>
REFERRED TO						DATE		
SIGNATURE								
TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 422								

PURPOSE: To have a uniform system of reporting to health department personnel requests for service and problems and situations of which they need to be aware.

EXPLANATION AND DEFINITIONS:

Name: This is the name of the individual requiring service. Father's and mother's names are to be given only when an infant or child is referred.

Newborn: Data from the certificate of live birth or hospital record are to be given for a newborn child being referred for service.

Expected Confinement Date: Antepartum cases may be referred on this form. If a case is referred, the expected confinement date is needed.

Address: This is the mailing address. The addition of community and directions aids in locating individual.

Private Physician: It is important to get the name of the private physician on all referrals which are for the public health nurse. If no private physician, name of clinic is obtained.

Reason for Referring: This space should give a clear understanding of message, problem, diagnosis and what is to be done.

How Referred: A check mark is placed in the boxes of referral, also the name of the hospital is given. Example: A private physician telephones to health department. A check mark is placed in the boxes by private physician, and by telephone.

Date: This is date of writing referral slip.

Signature: This should be the signature of the person receiving the referral request. If the clerk receives the message by telephone, she signs her name in this space.

USED BY: Private physician, health department clerk, and other local health department personnel.

OFFICE MECHANICS AND FILING: When this form is filled in, it is given to the person to whom referred, who keeps it until referral is handled and record of service made.

COMMENT: After recording the result of investigation on the proper health department record, this form may be returned to the person referring with a notation of the result of investigation on back. Example: The Pediatric Service at Meharry requested a nursing visit in Williamson County for an infant delinquent in Well Baby Clinic. The public health nurse visited the infant, recorded her service on the Health Record, Form 408, and made her reply on the back of this referral form and returned the form to the Pediatric Service at Meharry.

To keep the Crippled Children's Roster accurate it is advisable that this form, made out on birth injuries and/or congenital malformations obtained from Certificate of Live Birth, Form 100, be returned to the clerk when completed.

Pages 423-435 missing

[illegible]

BACK

[illegible]

PURPOSE: For local health department, Crippled Children's Service and field service record.

EXPLANATION AND DEFINITIONS:

Interested Individuals or Groups: Refers to persons or organizations sufficiently interested in the case to furnish money for transportation or other services not paid by Crippled Children's Service.

Reported by: Refers to physician reporting condition which brings child under classification of "crippled child". This may be the health officer or the private physician.

Immunity Status: Immunizations are to be recorded as on Health Record, Form 408.

Previous Medical Care: Refers to any medical care for crippling condition prior to date reported, whether by private physician, clinic or hospital.

Clinical History: Information from original examination records, Form 440, or other record of orthopedic examination.

Summary of Hospitalization and Special Care: This section is to be filled in when information is sent by Crippled Children's Service.

Appliances: The date of application of each new type of appliance and the type should be recorded here. This date is not changed until the type of appliance is changed.

Family Background - History of Illness in Family: Refers to family background including education of parents, and to medical history of family relating to condition of child - as history of tuberculosis, other congenital deformities, etc.

Childhood Diseases of Patient: List usual childhood diseases.

Personality - Special Interests - Recreational Facilities, etc.: Under this item should be given the child's desire for training or aptitude in special lines, his adjustment in the home, his ability to play well with others, etc.

Education: Here should be recorded the date, school and grade. This should show whether child is capable of keeping up regular course of study, and if not, what special arrangements are made.

Referral to Other Agencies: Self-explanatory.

USED BY: Nurse and clerk.

OFFICE MECHANICS AND FILING: This record is to be opened by the nurse when the case is reported as a crippled child. A Summary Record, Form 437, is made for the Regional Office of Crippled Children's Service. A Summary Record need not be forwarded to the regional office if the child has been examined in a State orthopedic clinic. The case is entered in Crippled Children's Roster, on Chronological Card, Form 207, and on Office Report Card, Form 208. The field record is then indexed, checked for immunity status and filed in the family folder.

11-3-47

CRIPPLED CHILDREN SUMMARY RECORD - FORM 437

PURPOSE: For report of cases to Crippled Children's Service and for record in central office of services rendered crippled children

EXPLANATION AND DEFINITIONS: Information regarding "Status of Case", "Date of Acceptance", "Report of Clinician or Orthopedist", "Summary of Hospital and Other Special Care", "Appliances Used", and "Outcome" are not to be filled in the counties. Other items are to be copied from Crippled Children Field Record, Form 436.

USED BY: Clerk

OFFICE MECHANICS AND FILING: The upper section of the front of this record is to be typed in by the clerk from the Crippled Children Field Record after the nurse's first visit, and is to be forwarded to the regional office of Crippled Children's Service. The "Status of Case", "Date of Acceptance", and "Report of Clinician or Orthopedist" are to be completed in the Tennessee Department of Public Health. If the child is seen in the clinic first, this summary record is not to be prepared because it has already been completed at the clinic.

11-3-47

Pages 438-439 missing

CRIPPLED CHILDREN'S SERVICE ORTHOPEDIC EXAMINATION RECORD - FORM 440

PURPOSE: To record findings and recommendations of orthopedic surgeons, both clinician and rotating surgeon.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Orthopedic surgeon, health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: Record is filled in by orthopedic surgeon. Field worker of Crippled Children's Service carries original to regional office, where copies are made. After copy has been returned to the county health department, it is routed over the health officer's desk, information is summarized to Crippled Children Field Record, Form 436, by the nurse, and the record is filed by the clerk in alphabetical arrangement in two sections - active and closed. Additional records will be sent as child is re-examined and all records for one child should be attached.

COMMENT: This examination does not obligate the Crippled Children's Service for treatment or care.

11-3-47

Page 441 missing

CRIPPLED CHILDREN'S SERVICE COMMITMENT - FORM 442
SIZE 11" x 8½"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH
Crippled Children's Service
NASHVILLE, TENNESSEE

STATE OF TENNESSEE
COUNTY OF

APPLICATION FROM PARENTS TO COUNTY JUDGE

The undersigned,, being the
(Parent or guardian)
in legal custody of, who is a crippled child, and who resides in the
(Name of child)
county aforesaid, hereby surrenders and requests that said child be committed to the County Judge
of said county to be placed under the care and custody of the CRIPPLED CHILDREN'S SERVICE,
Tennessee Department of Public Health, for necessary medical and surgical treatment.

The undersigned further certifies that he or she is unable to pay for the treatment of said child
and that there is no one legally responsible for the child's care, who is able to assume financial re-
sponsibility for this service.

This commitment is in accordance with Chapter 60, amended Public Acts of 1929, by the terms
of which I agree to be bound. I further agree that
(Name of child)
shall remain in the custody of the CRIPPLED CHILDREN'S SERVICE until treatment is completed
or the child is otherwise discharged.

Witness my hand, this the day of, 193....

.....
(Parent or guardian)

Address

Witness
Name

Address

COUNTY JUDGE'S COMMITMENT

Since, having legal charge of
(Parent or guardian) (Name of child)
is unable to pay the whole or any part of the treatment costs of said child, it is ordered that the said
child be, and is hereby committed to the care and custody of the CRIPPLED CHILDREN'S SER-
VICE of Tennessee Department of Public Health until treatment has been completed or the child
discharged by said service.

It is further agreed that County will assume full responsibility
and is hereby committed to pay one-half the cost of medical and surgical treatment of this child and
that all bills in connection with the treatment of this child will be paid promptly and in full each month
upon receipt of invoices for services rendered by or through the CRIPPLED CHILDREN'S SERVICE
of the Tennessee Department of Public Health. These conditions being in accordance with Chapter
60, amended Public Acts of 1929.

The commitment order of this child has been duly entered in the minutes of the court in Book
No....., Page.....

In testimony whereof, I have hereunto affixed my name and seal as County Judge and Fiscal
Agent of County, State of Tennessee, this the day of, 193....

....., County Judge

..... County, Tennessee

CRIPPLED CHILDREN'S SERVICE COMMITMENT - FORM 442

PURPOSE: To give Crippled Children's Service authority to institute and follow through such corrective measures as they see fit, and to insure financial cooperation by the county.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Health officer, nurse, parents, county judge and Crippled Children's Service.

OFFICE MECHANICS AND FILING: A member of the local health department assists the family in completing three copies of the commitment form. This done after eligibility to Crippled Children's Service is determined. One copy is left with the county judge, one copy is given to the family and one copy sent to the Regional Office of Crippled Children's Service. The date on which the judge signs the commitment forms is entered on the Crippled Children Field Record, Form 436.

COMMENT: No orthopedic service other than original examination will be furnished until these forms are completed and a copy is on file in the Regional Office of Crippled Children's Service.

11-3-47

Pages 443-444 missing

CRIPPLED CHILDREN'S SERVICE
AUTHORIZATION FOR SERVICE - FORM 445
SIZE 5½" x 8½"

<p>CRIPPLED CHILDREN'S SERVICE AUTHORIZATION FOR SERVICE</p>	
<p>AUTHORIZATION NUMBER _____</p>	<p>_____ 19 _____</p>
<p>NAME _____</p>	<p>COLOR _____</p>
<p>SEX _____ AGE, OF _____</p>	<p>COUNTY _____</p>
<p>IS LEGALLY COMMITTED TO THIS SERVICE. AUTHORIZATION IS HEREBY GIVEN FOR ORTHOPEDIC AND PLASTIC CARE, INCLUDING NECESSARY HOSPITALIZATION AND/OR APPLIANCES, IN ACCORDANCE WITH OUR AGREEMENT WITH SAID COUNTY AND AS SET FORTH IN HOUSE BILL No. 507, CHAPTER 60.</p>	
<p>_____, DIRECTOR</p>	
<p><small>TENNESSEE DEPARTMENT OF PUBLIC HEALTH - FORM 445</small></p>	

PURPOSE: To notify county health departments, Regional Offices of Crippled Children's Service, hospitals and appliance houses of acceptance to Crippled Children's Service.

EXPLANATION AND DEFINITIONS: When a case is accepted by the Director of Crippled Children's Service, four copies of Form 445 are made. One is kept in the Central Office of Crippled Children's Service, and three are sent to the Regional Office of Crippled Children's Service. The Regional Office keeps one copy, sends one to the county health department and one to the hospital or appliance house.

USED BY: Hospitals, appliance houses, Crippled Children's Service and local health departments.

OFFICE MECHANICS AND FILING: The dates from Form 445 are transcribed on the Crippled Children Field Record, Form 436, and Form 445 is filed in the Miscellaneous File for Crippled Children's Service.

COMMENTS: Estimated costs do not appear on Form 445 since this is shown on the examination record. At the time of examination a special order blank with estimated cost of expenditure (hospitalization or appliance) is made out in duplicate at clinic. One copy is sent to the hospital or appliance house with the patient, and one copy is attached to the examination record and sent to the Central Office of Crippled Children's Service.

Pages 446-447 missing

CRIPPLED CHILDREN'S SERVICE
HOSPITAL ADMISSION AND DISCHARGE CARD - FORM 448
SIZE 3" x 5"

FRONT

THIS SIDE OF CARD IS FOR ADDRESS

BACK

Date _____

Authorization Number _____

NAME _____

County _____

ADDRESS _____

was Admitted to _____ this hospital on above date on authorization from Crippled Children's
Discharged from _____

Service under date of _____ for _____
(LENGTH OF TIME)

NAME OF HOSPITAL _____

By _____

TENNESSEE DEPARTMENT OF PUBLIC HEALTH FORM NO. 448

CRIPPLED CHILDREN'S SERVICE
HOSPITAL ADMISSION AND DISCHARGE CARD - FORM 448

PURPOSE: To inform local health departments of dates of admission to and discharge from hospital or convalescent home.

EXPLANATION AND DEFINITIONS: Information by hospital admitting office.

USED BY: Nurse and clerk.

OFFICE MECHANICS AND FILING: These cards are for information only and may be destroyed after dates are transcribed to Crippled Children Field Record, Form 436.

11-3-47

Pages 449-451 missing

CRIPPLED CHILDREN'S SERVICE
PHYSICIAN'S FOLLOW-UP INSTRUCTIONS - FORM 452
SIZE 11" x 8½"

CRIPPLED CHILDREN'S SERVICE
PHYSICIAN'S FOLLOW-UP INSTRUCTIONS

Name	County	Authorization Number								
Address										
Parent's or Guardian's Name										
The above-named patient may be discharged _____ to own home _____ to convenient home _____										
Present condition (specific): _____ _____ _____ _____ _____										
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Patient to use: Crutches</td> <td style="width: 50%;">Complete bed rest</td> </tr> <tr> <td>Cast</td> <td>Up hours daily</td> </tr> <tr> <td>Braces</td> <td>Activity unrestricted</td> </tr> <tr> <td>Wheel chair</td> <td></td> </tr> </table>			Patient to use: Crutches	Complete bed rest	Cast	Up hours daily	Braces	Activity unrestricted	Wheel chair	
Patient to use: Crutches	Complete bed rest									
Cast	Up hours daily									
Braces	Activity unrestricted									
Wheel chair										
(Check (X) conditions applicable and explain as indicated)										
Dressings to be done _____ times per week at _____ (Specify place)										
Medication: _____ _____ _____										
Physiotherapy (type, place, etc.) _____ _____ _____										
May return to school (Date, precautions or restrictions, etc.) _____ _____ _____										
Instructions as to diet: _____ _____ _____										
Return to _____ on _____ (Hospital or clinic) (Date or at stated interval)										
Special instructions (indicate patient's attitude toward examination): _____ _____ _____										
Date _____ Signed _____, M.D.										

CRIPPLED CHILDREN'S SERVICE
PHYSICIAN'S FOLLOW-UP INSTRUCTIONS - FORM 452

PURPOSE: To furnish recommendations of orthopedic surgeon treating the case for follow-up service.

EXPLANATION AND DEFINITIONS: Information is filled in by orthopedic surgeon treating case.

USED BY: Health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: When the copy is received by the local health department, this record should be routed to the health officer, and then routed to nurse for summary on Crippled Children Field Record, Form 436. It is then filed in the Miscellaneous File for Crippled Children's Service. It is recommended that all records (with the exception of Crippled Children Field Record, Form 436, and Crippled Children's Service Examination Record, Form 440) and correspondence for each child be stapled together in chronological order, with the most recent date on top, and arranged alphabetically in as many folders as are necessary.

11-3-47

Pages 453-455 missing

REFERRAL FROM CRIPPLED CHILDREN'S SERVICE TO
 VOCATIONAL REHABILITATION - FORM 456
 SIZE 11" x 8½"

FRONT

REFERRAL FROM CRIPPLED CHILDREN'S SERVICE TO
 VOCATIONAL REHABILITATION

NAME: _____ DATE: _____
LAST FIRST MIDDLE

COLOR: _____ SEX: _____ DATE OF BIRTH: _____

ADDRESS: _____ COUNTY _____
STREET CITY ROUTE

DIRECTIONS FOR REACHING HOME: _____

EDUCATION AND OTHER INTERESTS: _____

PARENT OR GUARDIAN: _____
LAST FIRST MIDDLE

I. MAJOR DISABILITY - (A) DESCRIPTION AS TO NATURE AND CONDITION _____

(B) CAUSE OF DISABILITY _____ DATE OF ONSET _____

(C) SUMMARY OF TREATMENT _____

(D) COMPLICATIONS _____

(E) CHARACTERISTICS OF DISABILITY (CHECK): STABLE _____ PROGRESSIVE _____

IMPROVING _____ RECURRENT _____ PERMANENT _____ INFECTIOUS _____

(F) DEGREE OF RESIDUAL FUNCTIONING OF PART AFFECTED (CHECK): GOOD _____ FAIR _____

(G) CAN FUNCTIONING BE IMPROVED: BY MEDICAL OR SURGICAL TREATMENT? _____

IF SO, NATURE _____

BY PROSTHETIC APPLIANCE, KIND _____

BY OTHER THERAPY, KIND _____

(OVER)

BACK

REFERRAL (Continued)

(H) WILL TREATMENT BE CONTINUED BY CCS? _____

II. PROGNOSIS - (A) AS TO IMPROVEMENT IN PHYSICAL CONDITION:

WITH TREATMENT _____

WITHOUT TREATMENT _____

(B) AS TO LONGEVITY AND GENERAL HEALTH:

WITH TREATMENT _____

WITHOUT TREATMENT _____

(C) AS TO WORK CAPACITY (IN A PHYSICALLY ACTIVE JOB):

WITH TREATMENT _____

WITHOUT TREATMENT _____

III. PRECAUTIONS TO BE TAKEN AS TO

(A) TYPES OF ACTIVITY TO BE AVOIDED _____

(B) WORKING CONDITIONS TO BE AVOIDED _____

(C) IS MEDICAL CHECK-UP NECESSARY? _____ IF SO, HOW OFTEN? _____

IS PATIENT NOW PHYSICALLY FIT TO ENTER EMPLOYMENT OR TO ENTER TRAINING FOR EMPLOYMENT ON
FULL-TIME BASIS? _____ IF NOT, WHY? _____

DATE OF LAST EXAMINATION: _____

IV. PHYSICIAN'S RECOMMENDATIONS _____

COMMENTS: (SOCIAL INFORMATION, ATTITUDE TOWARD TRAINING, ETC.) _____

PLACE _____

DATE _____

(SIGNATURE OF PHYSICIAN OR OF HOSPITAL OR CLINIC
OFFICIAL)

REFERRAL FROM CRIPPLED CHILDREN'S SERVICE TO
VOCATIONAL REHABILITATION - FORM 456

PURPOSE: To refer each crippled child on or before six months prior to the sixteenth birthday to Vocational Rehabilitation Service for vocational training, or to refer a crippled child for continued medical care six months before reaching twenty-one years of age.

EXPLANATION AND DEFINITIONS: This form contains information to aid Vocational Rehabilitation in giving consideration to vocational guidance and/or training suitable to the patient's physical condition; and to give an up-to-date summary of the patient's treatment under Crippled Children's Service.

The county nurse will fill out the introductory part of this form, i.e., name, color, address, etc., and in addition under Part I, (a), description as to nature and condition as regards major disability. The form is then sent to the Regional Office of Crippled Children's Service for referral to the Central Office of Crippled Children's Service. It shall be the responsibility of the Medical Director of Crippled Children's Service to complete Parts I, II, III and IV. A few words by the nurse under Part I (a), description as to nature and condition of disability, will be extremely helpful in the total evaluation of the patient. The nurse may feel free to use the paragraph "Comments" on the back side of the form if she needs additional space.

USED BY: Nurse, Regional Office of Crippled Children's Service, Central Office of Crippled Children's Service and Vocational Rehabilitation.

OFFICE MECHANICS AND FILING: Notation is made on nurse's field record, Form 436, when completed and this form is sent to the Regional Office of Crippled Children's Service.

Pages 457-459 missing

EDUCATIONAL NEEDS FOR A HANDICAPPED CHILD - FORM 460
SIZE 11" x 8½"

EDUCATIONAL NEEDS FOR A HANDICAPPED CHILD

NAME: _____ DATE _____

LAST

FIRST

MIDDLE

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____ COLOR _____ SEX _____ GRADE IN SCHOOL _____

ADDRESS: _____ COUNTY _____

STREET

CITY

ROUTE

DIRECTIONS FOR REACHING HOME: _____

PARENT OR GUARDIAN: _____

LAST

FIRST

MIDDLE

ADDRESS IF DIFFERENT FROM CHILD'S: _____

CHILD'S CRIPPLING CONDITION: _____

1. IS THIS CHILD ABLE TO ATTEND SCHOOL? _____

2. DOES THE CHILD ATTEND SCHOOL? _____

3. HOW LONG HAS CHILD BEEN ABSENT FROM SCHOOL? _____

4. HOW FAR FROM SCHOOL? _____

BLOCKS OR MILES

5. IS TRANSPORTATION AVAILABLE? _____ PRIVATE _____ PUBLIC _____

6. HOW FAR WOULD CHILD HAVE TO WALK TO REACH BUS? _____

7. COULD CHILD CLIMB STEPS OF SCHOOL BUILDING? _____

8. IS CHILD HOME-BOUND? _____ WEAR BRACES? _____ USE CRUTCHES? _____

9. NAME OF SCHOOL LAST ATTENDED: _____

10. NAME OF SCHOOL CHILD WILL ATTEND: _____

REMARKS: (DOES HE HAVE A HOBBY OR HAS HE EVER HAD A JOB?) _____

 SIGNATURE OF PERSON MAKING REPORT

EDUCATIONAL NEEDS FOR A HANDICAPPED CHILD - FORM 460

PURPOSE: This form may be used by nurses to report needs for Special Education Services such as transportation, special desks, chairs, lighting, books with large, clear type, special teachers, speech correction, facilities for hard-of-hearing, or any other services for physically handicapped, (crippled, hard-of-hearing, speech defectives, partially sighted, deaf, blind, lowered vitality, epileptic, cardiac, rheumatic fever).

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Nurses, local school personnel and special teachers.

OFFICE MECHANICS AND FILING: Three copies should be prepared, the *white* copy is to be mailed to the county or city superintendent of schools, the *yellow* copy is to be mailed to the Supervisor of Special Education, 420 Sixth Avenue North, Nashville, Tennessee, and the *blue* copy is to be retained in the local health department. A notation is made on Crippled Children Field Record, Form 436, and this form is filed in the Miscellaneous File for Crippled Children's Service.

This form will also be used by the Department of Education and Welfare:

The Regional Office of Crippled Children's Service will make out this form when a child is admitted to the hospital or convalescent home and mail the *white* copy directly to the local county or city superintendent, or school, mail the *yellow* copy to the regional supervising principal, and keep the *blue* copy in the regional office.

A report of the child's progress while in the hospital is sent by the Department of Education to the local county or city superintendent, or school, and a copy of this report is also sent to the local health department.

Pages 461-475 missing

DENTAL REPORT CARD - FORM 476
SIZE 3" x 5"

FRONT

DENTAL REPORT CARD

NAME OF CHILD _____ SHOULD VISIT
 THE DENTIST FOR EXAMINATION AND NECESSARY DENTAL WORK. THIS VISIT IS
 VERY IMPORTANT. EVEN IF THE TEETH LOOK ALL RIGHT. PLEASE HAVE THE DEN-
 TIST CHECK AND SIGN THIS CARD AND GIVE TO THE INDIVIDUAL TO RETURN TO
 SCHOOL.

DATE _____ TEACHER OR NURSE

() I HAVE EXAMINED THE ABOVE INDIVIDUAL AND FIND NO
 * FILLINGS, EXTRACTIONS OR CLEANING REQUIRED.

() I HAVE EXAMINED THE ABOVE INDIVIDUAL AND FIND THE
 FOLLOWING DENTAL WORK NEEDED:

() FILLINGS () EXTRACTIONS () CLEANING

APPOINTMENT HAS BEEN GIVEN: DATE _____

DATE _____ DENTIST

() I HAVE COMPLETED ALL NECESSARY FILLINGS, EXTRAC-
 TIONS AND CLEANING FOR THE ABOVE INDIVIDUAL TO
 DATE.

DATE _____ DENTIST

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 476

BACK

DENTAL STANDARDS

1. RESTORATION OF ALL (FILLABLE) DECAYED TEETH BY METALLIC
 OR CEMENT FILLINGS.
2. EXTRACTION OF ALL ROOTS, NON-VITAL OR ABSCESSSED TEETH OR
 THEIR PROPER TREATMENT AND SUBSEQUENT FILLING.
3. CORRECTION OF ALL SEPTIC MOUTH CONDITIONS BY THE REMOVAL
 OF STAINS, TARTER, TREATMENT OF DISEASED GUMS, FAULTY
 DENTAL WORK, ANY SURGICAL REQUIREMENTS.
4. TREATMENT BY SILVER NITRATE OF ALL UNFILLABLE CAVITIES IN
 VITAL TEETH WHICH PROBABLY WILL BE LOST WITHIN SIX
 MONTHS.

EXPLANATION AND DEFINITIONS: This form replaces the Dental Certificate. Health Officers, nurses and teachers are supplied with these forms to be given to the children so that reports of examination and corrections of defects can be made.

The child takes the card to the dentist who completes the section for the examination and for treatment, if given. The child returns the card to the teacher.

The dentists are supplied by the health department with cards for use when additional appointments are given and complete treatment is received.

USED BY: Health officer, nurse, clerk, dentist and teacher.

DENTAL PROGRAM ANNOUNCEMENT - FORM 477
SIZE 5" x 8"

DENTAL PROGRAM ANNOUNCEMENT

TO PARENT OR GUARDIAN:

YOU ARE URGED TO BE PRESENT AT A DENTAL DEMONSTRATION PROGRAM CONDUCTED AT YOUR SCHOOL ON _____ BY A DENTIST OR DENTAL HYGIENIST WITH THE TENNESSEE DEPARTMENT OF PUBLIC HEALTH WORKING WITH YOUR LOCAL HEALTH DEPARTMENT.

USUALLY, TIME LIMITS DENTAL INSPECTIONS TO ONLY THOSE CHILDREN WHOSE PARENTS ARE PRESENT. IN ADDITION A LIMITED NUMBER OF PREVIOUSLY SELECTED CHILDREN WILL RECEIVE DENTAL CARE, AS A METHOD OF SHOWING THE SCHOOL CHILDREN WHAT A VISIT TO THE DENTIST IS LIKE. WHERE GOOD FACILITIES ARE AVAILABLE, A MOTION PICTURE ON DENTAL HEALTH MAY BE SHOWN.

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 477

PURPOSE: A form announcing to the parents the date when the dental demonstration program will be held at the school.

EXPLANATION AND DEFINITIONS: These forms are provided to the school authorities by the person from the local health department who is responsible for the arrangement of the dental program. The teacher fills in the date of the dental demonstration program and distributes them to the children.

USED BY: Superintendent of school, teachers and local health department personnel.

3-14-49

REQUEST FOR DENTAL SERVICE - FORM 478
SIZE 5" X 8"

REQUEST FOR DENTAL SERVICE	
_____ NAME OF SCHOOL	_____ DATE
<p>I REQUEST THAT _____ <small>NAME OF CHILD</small></p> <p>BE GIVEN DENTAL TREATMENT, WITHOUT COST TO ME, BY A DENTIST OR DENTAL HYGIENIST WORKING WITH THE HEALTH DEPARTMENT.</p>	
<p>SIGNED _____ <small>PARENT OR GUARDIAN</small></p>	
_____ TEACHER	_____ GRADE
TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 478	

PURPOSE: A form giving the dentist authority to perform dental service.

EXPLANATION AND DEFINITIONS: To provide a written consent for dental treatment. It is to be used by dentists or dental hygienists working with state, county or city health departments. It is also to be used by the private dentists working on the cooperative dental program.

These forms are given to the school authorities by the local department of education or by the person from the local health department who is responsible for the arrangement of the dental program.

USED BY: Dentist, dental hygienist, superintendent of school, teacher and local health department personnel.

OFFICE MECHANICS AND FILING: These slips are for the protection of the dentists and are to be filed in the dentist's office or the local health department for a period of at least six months.

Page 479 missing

REPORT OF EXAMINATIONS AND CORRECTIONS
COOPERATIVE DENTAL PROGRAM - FORM 480

PURPOSE: To provide a complete record of work done in each school under the cooperative dental program.

EXPLANATION AND DEFINITIONS:

Case Completed: A completed case is a case with all existing dental defects corrected, and may be so recorded on the individual's health record, Form 408.

USED BY: Dentist, health officer and clerk.

OFFICE MECHANICS AND FILING: The Report of Examinations and Corrections, Form 480, is to be submitted by each cooperating dentist to the local health department at such time as the health officer may designate. These reports are to be summarized for each dentist by the clerk of the local health department on the Summary Report-Cooperative Dental Hygiene Program, Form 484. The Report of Examinations and Corrections are to be retained in the files of the local health department, attached to a copy of the Summary Report, so as to be available upon request.

A Summary Report, Form 484, for each dentist is to be submitted to the Director of Local Health Service not later than the *tenth* of the month following the close of each fiscal quarter.

A statement in duplicate signed by the dentist on his own office stationery and prepared in the following manner will be used:

FOR DENTAL SERVICES RENDERED

\$ _____ Total amount earned

\$ _____ Less amount received from local sources

\$ _____ Amount due from Tennessee Department of Public Health

_____ D.D.S.

These duplicate statements are submitted by the local health department with duplicate copies of the Summary Report, Form 484. Vouchers will then be issued and mailed directly to each cooperating dentist for the amount of State funds due him for services rendered during the period covered by the Summary Report.

COMMENT: All local funds due for dental services are to be collected by the health officer and paid by him to the cooperating dentists. *Payments made directly to dentists by voluntary agencies or individuals will not be subject to the matching arrangement provided in this program.*

Pages 481-483 missing

SUMMARY REPORT - COOPERATIVE DENTAL HYGIENE PROGRAM - FORM 484
SIZE 8½" x 11"

[illegible]

PURPOSE: To provide a summary for each dentist of work done and amount expended under the cooperative dental program.

EXPLANATION AND DEFINITIONS: Self-explanatory.

USED BY: Health officer and clerk.

OFFICE MECHANICS AND FILING: This form is prepared in triplicate for each dentist from the Report of Examinations and Corrections, Form 480. Duplicate copies of the form for each dentist are to be submitted to the Director of Local Health Service not later than the tenth of the month following the close of each fiscal quarter.

A statement in duplicate signed by the dentist on his own office stationery and prepared in the following manner will be used:

FOR DENTAL SERVICES RENDERED

\$_____ Total amount earned

\$_____ Less amount received from local sources

\$_____ Amount due from Tennessee Department of Public Health

COMMENT: It is from this form that the Dental Hygiene Service figures the cost per operation, number of children treated, etc.

Pages 485-499 missing

FAMILY FOLDER - FORM 500
SIZE 5" x 8"(FOLDED)

OUTSIDE

Name	Color	Nursing District			
	Mailing Addresses	Civil District			
	1.				
	2.				
	3.				
	4.				
			DIRECTIONS FOR LOCATING		Date
		Community			

INSIDE

HOUSEHOLD ROSTER		Sex	Date of Birth	Date of Death	Cause of Death
Husband					
Wife					
MAIDEN NAME					
Children					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
Other		Relationship			
1.					
2.					
3.					
4.					
5.					
6.					

SUMMARY OF INDIVIDUAL RECORDS				
Individual Carried	Date Admitted	Type of Record	Date Closed	Reason for Closing

SOCIAL AND ECONOMIC DATA	
Date	

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 500

PURPOSE: To provide means of assembling all family data as a unit to be used in field visits to the family. In the family folder are filed all open field records (except Health Records, Form 408, filed in general preschool folders and school folders) of members of a given family.

EXPLANATION AND DEFINITIONS:

Name: The name on the family folder will be the name of the head of the household.

In instances where there are two distinct families living in one household, the name of the head of the family concerned will be used. Where two family folders exist for one premise, reference should be made to the other family on the family folder, e.g., "see also family folder for John Jones." It is suggested that this be written on the outside of the family folder.

Household Roster: At the time this information is obtained all members of a family, living or dead, should be listed in this space. This will include also children of a previous marriage living in the home.

Relatives and others living in the home should be listed under "Other", with relationship stated on the same line.

Summary of Individual Records: This section is largely self-explanatory. Space is provided for entry, in the family folder, of data referring to any individual's records when closed.

Social and Economic Data: This space is provided for useful information on economic condition of the family, environmental sanitation, type of house, special health problems and availability of medical service. Supplemental Social and Economic Data, Form 501, may be used to supplement this space when that on the family folder has been completely filled in.

Directions for Locating: For easy reference by the field worker a space is provided for the directions for locating the family on the outside of the family folder. Any change of address requires a change in directions. It will be preferable to have directions written in ink and not erased when a change is made.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: The family folder is carried into the home by the nurse and essential data are entered at the time of first visit to the home. The folder and contents are then attached to the daily, enroute to the clerk for indexing and checking the records in the folder.

When there is no further need for the record of a given individual in a family folder, that record is withdrawn. To close a record the entire folder is attached to the daily and routed to the clerk. The clerk fills in data required under "Summary of Individual Records", and makes necessary note on index cards of records concerned. An individual record, contained in the folder may be removed as follows: Children--death or removal from county; Adults--death, removal from county, or recovery. The communicable disease record in the family folder is to be closed and removed from the folder when the case is released. Health records for preschool children may be transferred to the general preschool file, and health records for children of school age may be placed in the school file. A summary of the communicable disease record is made on the Health Record, Form 408, and upon any other special open record that the individual has. If the family as a whole is closed, the records of individual members are no longer kept together as a unit. Proper notations are made on the folder under "Summary of Individual Records", and every record except the Family Record, Form 413, is removed from the folder and filed according to type, in the closed file. The family folder containing the family record is filed alphabetically in the closed file. Should the necessity arise, these records may be reassembled.

COMMENT: No attempt is made in the family folder to anticipate every aspect of the family situation. However, if the wife listed at the time the folder is made is divorced or dies, and the husband remarries, the new wife is placed under "other" with the relationship explained.

SUPPLEMENTAL SOCIAL AND ECONOMIC DATA - FORM 501
SIZE 10" x 8"

FRONT

[illegible]

BACK

[illegible]

SUPPLEMENTAL SOCIAL AND ECONOMIC DATA - FORM 501

PURPOSE: To provide additional space when needed in order to keep social and economic data on families current.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: This form may be used to supplement space provided for social and economic data on the family folder when additional space is needed.

COMMENT: This form is provided in order that useful information will not be lost because of personnel changes, etc.

11-3-47

APPOINTMENT FOR EXAMINATION - FORM 502
SIZE 3" x 5"

APPOINTMENT FOR EXAMINATION			
NAME _____	COLOR _____	SEX _____	AGE _____
ADDRESS _____	CITY OR COUNTY _____		
REPORT TO _____			
DAY AND HOUR _____			
REMARKS _____			

DATE _____ REFERRED BY _____			
TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 502			

PURPOSE: To give a written notice of date and place for appointment for examination; and to furnish clinician with authority to admit persons to the clinics.

EXPLANATION AND DEFINITIONS: Items are self-explanatory.

USED BY: Health department personnel, private physician and patient.

OFFICE MECHANICS AND FILING:

Tuberculosis: This form is to be signed by the private physician to furnish the health department with the authority to admit persons to the tuberculosis case finding service. "Tuberculosis Case Finding Clinic" should be entered under "Remarks". This record (completed) must be on file for each person admitted to tuberculosis case finding service.

This form is kept on file, by clinic date, in the office of the county health department for one year.

Venereal Disease: This form is to be filled out by the field worker when a visit is made to a contact of a venereal disease case for the purpose of giving the contact an appointment for examination in the health department.

TYPE OF SERVICE DESIRED *MUST NOT* BE ENTERED ON RECORD FOR VENEREAL DISEASE CONTACT.

These slips may be destroyed when contacts attend the clinic.

Other: Type of service desired must be entered under "Remarks". Appointment for examination slips may be destroyed after being presented to the health department with the exception of those used to admit persons to the tuberculosis case finding service.

Pages 503-504 missing

BOX CHECK - FORM 505
SIZE 11" x 8½"

[illegible]

PURPOSE: To furnish the nurse with a list of families by communities so that she may plan her visits, giving consideration to the most essential needs of service and the saving of time and transportation.

EXPLANATION AND DEFINITIONS: Under "Type of Service", make check marks (✓) in the appropriate spaces indicating records in family folder. Under "Needs Immunization", make check marks (✓) indicating types of immunizations needed. Under "Special Problems", the nurse will make notations that will be helpful to her in handling the case.

USED BY: Nurse.

OFFICE MECHANICS AND FILING: On the first of each calendar year all family folders should be listed on this form by community, spaces as indicated should be checked. The names of family folders are listed alphabetically. If the family moves into another nursing district within the county, the name should be placed on the box check of the community to which the family moves. If the family moves from the county, a line should be drawn through the name and a notation made indicating disposition of the family. It is recommended that these completed records be placed in a loose leaf notebook and kept in the nurse's desk for daily use.

Pages 506-549 missing

TUMOR CLINIC REFERRAL RECORD - FORM 550
SIZE 5" x 8"

TUMOR CLINIC REFERRAL RECORD			
NAME	COLOR	SEX	AGE DATE
ADDRESS	COMMUNITY		COUNTY
PHYSICIAN	ADDRESS		
DIAGNOSIS:			
TREATMENT: OPERATION ; IRRADIATION ; RADIUM ; OTHER			
WHAT DOES PATIENT KNOW ABOUT CONDITION?			
WHAT DO YOU WANT PATIENT TOLD ABOUT CONDITION?			
WHEN IS PATIENT TO RETURN TO CLINIC FOR OBSERVATION OR TREATMENT?			
RECOMMENDED FOLLOW-UP:			
REPORTING CLINIC: NAME			
WORKER			

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - FORM 550

PURPOSE: To inform the local health department of the diagnosis in a tumor clinic for follow-up service by the nursing staff.

EXPLANATION AND DEFINITIONS: This record which is to be prepared in tumor clinics and sent to health departments gives the diagnosis and treatment received in the clinic or hospital. Answers to the questions, "What does patient know about condition?" and "What do you want patient told about condition?" should aid the nurse in her visit to the patient. Although the diagnosis for some of the patients may be cancer, we do not know that the patient knows the diagnosis. Thus the nurse should not give out any information regarding diagnosis.

USED BY: Health department personnel.

OFFICE MECHANICS AND FILING: The information from this record should be transferred to Record of Tumor Clinic Patient, Form 560.

After the record has been used and information transferred to Form 560 it is to be filed alphabetically with other referral records from tumor clinics and kept indefinitely.

Pages 551-559 missing

RECORD OF TUMOR CLINIC PATIENT - FORM 560
SIZE 10" x 8"

FRONT

RECORD OF TUMOR CLINIC PATIENT

NAME	COLOR	SEX	DATE OF BIRTH
MARITAL STATUS	REFERRED BY	DATE REFERRED	DATE INVESTIGATED
OCCUPATION	INDUSTRY		
ADDRESS	PHYSICIAN	ADDRESS	
1.	1.		
2.	2.		
3.	3.		
4.	4.		

HISTORY OF ILLNESS (SYMPTOMS, ONSET)

CLINIC REPORT

DATE	REFERRING CLINIC	DIAGNOSIS

WHAT DOES PATIENT KNOW OF CONDITION? (GIVE DATES OF ANSWERS.)

WHAT DOES THE DOCTOR WISH PATIENT TOLD ABOUT CONDITION?

WHEN IS PATIENT TO RETURN TO CLINIC FOR TREATMENT OR OBSERVATION?

RECOMMENDED FOLLOW-UP

SUMMARY OF HOSPITALIZATION

DATE ADMITTED	PLACE	TREATMENT	DATE DISCHARGED

OTHER TREATMENT

BACK

[illegible]

PURPOSE: To provide clinical and treatment data and records of field observations (visits) of patients referred from tumor clinics or other sources.

EXPLANATION AND DEFINITIONS:

Referred by: Source of report - tumor clinic, physician, hospital, etc., if given here.

Date Referred: Date that report or referral record is received.

Date Investigated: Date visited by a member of health department staff.

Occupation and Industry: The kind of work and the kind of industry where patient has worked should be given.

History of Illness: The nature and date of onset of symptoms and symptoms from onset to the present should be given.

Clinic Report: Diagnoses from clinics, private physicians, hospitals, etc., should be recorded here.

The answers to the questions, "What does patient know of condition?", "What does the doctor wish patient told about condition?" and "When is patient to return to clinic for treatment or observation?" should be recorded with the date each time such information is obtained from referral records.

Summary of Hospitalization: The treatment received in the hospital as major operation, radium, irradiation, etc., should be recorded.

Nursing Notes: The observations made during visits are given in this section.

OFFICE MECHANICS AND FILING: This record is to be opened by the health officer or nurse on the date investigated. The record is to be indexed by the clerk and filed in the family folder. When the record is closed, a summary is made on the family folder and the record is filed in the closed tumor file.

Pages 561-599 missing

LABORATORY FORMS - FORMS 600, 602, 603,
604, 605, 606, 608, 609, 610, 610-2, 610-3, 611

MISCELLANEOUS EXAMINATION REQUEST FORM - FORM 600
SIZE 5" x 8"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE MISCELLANEOUS EXAMINATION REQUEST FORM			
SUBMIT ONE OF THESE BLANKS PROPERLY FILLED IN FOR EACH TYPE OF EXAMINATION DESIRED. USE SPECIAL BLANK PROVIDED FOR REQUESTING EXAMINATIONS FOR SYPHILIS			
PATIENT'S NAME _____		ADDRESS _____ COUNTY _____	
AGE _____	SEX _____	COLOR _____	MARITAL STATUS _____ OCCUPATION _____
SPECIMEN OF _____		DATE COLLECTED _____ 19____	
SPECIFY BLOOD, FECES, SPUTUM, ETC.			
TO BE EXAMINED FOR _____			
BE SPECIFIC AS TO EXAMINATION DESIRED AS MALARIA, DIPHTHERIA, ETC.			
FOR: DIAGNOSIS <input type="checkbox"/> CARRIER <input type="checkbox"/> FOODHANDLER <input type="checkbox"/> RELEASE <input type="checkbox"/> CHECK ON TREATMENT <input type="checkbox"/> OTHER _____			
(SPECIFY)			
CLINICAL REMARKS: _____			
DO NOT WRITE IN THIS SPACE			
LABORATORY NUMBER _____	DATE RECEIVED _____	DATE REPORTED _____	
		REPORTED BY _____	
RESULT _____		PHYSICIAN _____	
		STREET _____	
		CITY _____	
		COUNTY _____	
		(WRITE PLAINLY)	
		RESULTS OF EXAMINATIONS WILL BE MAILED UNLESS OTHERWISE DIRECTED-- TELEPHONE OR TELEGRAPH REPORTS WILL BE SENT COLLECT.	
		TENN. DEPT. OF PUBLIC HEALTH FORM 600	
EXAMINED BY _____			

BACK

In complying with the following suggestions, you will materially assist the Laboratory to assist you.

DIPHTHERIA CULTURES: Use no antiseptic in the mouth or nose for several hours before culture is taken. Depress tongue and rub swab thoroughly against any membrane, exudate or inflamed area in throat, revolving swab in the fingers in such a manner as to bring all portions of the cotton in contact with suspected area. If no membrane is visible, press swab far back against pharynx and tonsils, avoiding the tongue. **DO NOT PERMIT SWAB TO TOUCH ANYTHING EXCEPT AREA TO BE SWABBED;** place swab immediately in glass tube; replace plug and pack tube in mailing case. **MAIL URGENT SPECIMENS BY SPECIAL DELIVERY.**

ENTERIC CULTURES:

Blood Culture for Typhoid or the Paratyphoids: 8 to 10 cc. of whole blood should be collected and sent to the laboratory in the special containers provided. Do not discard the fluid in the container.

Stool and Urine Culture for Typhoid, Dysentery, or the Paratyphoids: Place feces to the amount the size of a small bean, or urine to the amount of 10 to 15 cc. in the special containers as indicated. Do not discard the fluid in the container.

INTESTINAL PARASITES: Place a small amount of feces from a normal movement in the container provided.

MALARIA, GONORRHEA, VINCENT'S AND OTHER SMEARS: After washing the glass slides, cleanse with alcohol or ether and let thoroughly dry before using. For Malaria Thick Blood Drop--cleanse finger tip with alcohol, puncture and obtain several large drops of blood; touch under side of slide near one end to drops of blood and rotate slide to spread blood in circle about 1/2 inch in diameter; turn slide with blood side up and allow to thoroughly dry, protected from flies, dust, etc. Forward slides to the Laboratory in the special slide containers.

PNEUMONIA:

Blood Culture: 5 to 8 cc. of whole blood should be collected aseptically and sent to the laboratory as soon as possible in the special container provided for this purpose. Do not discard the fluid in the container.

Sputum For Typing: An amount of sputum equal to at least one teaspoonful should be collected directly in the clean sterile container provided for this purpose and sent to the laboratory immediately. No fluid is present in this container.

RABIES: If a suspected rabid animal bites, or comes in contact with a person, confine the animal for 10 days observation. A rabid animal usually dies in that time and the head can then be sent to the laboratory for confirmatory diagnosis. Laboratory findings are not always satisfactory if the dog is killed. **Cauterize promptly all wounds thoroughly with fuming nitric acid.** With bites upon the face, neck and head, it is important to start prophylactic treatment at once. Dead animal heads should be placed in a tin container, packed with enough sawdust and ice to prevent decomposition en route, and sent to the nearest laboratory for examination.

TUBERCULOSIS: Morning specimens of sputum are preferred. Collect sputum in special sputum container. **DO NOT DISCARD THE CARBOLIC ACID IN THE BOTTLE.**

IMPORTANT NOTES:

1. No specimens will be examined unless submitted as directed or in the mail outfits. Mailed specimens shall be prepaid.
2. For instructions in collecting specimens other than indicated above, consult the Director of the State Laboratory nearest you.
3. In counties and cities with full time health service secure containers from local health department, otherwise secure from nearest laboratory.

Page 601 missing

WATER EXAMINATION REQUEST FORM - FORM 602

SIZE 5" x 8"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE WATER EXAMINATION REQUEST FORM

OWNER OF SUPPLY: _____ LOCATION OF SUPPLY: _____

SAMPLE COLLECTED BY: _____ ADDRESS: _____ COUNTY: _____

CLASSIFICATION OF SUPPLY: PUBLIC ☐ PRIVATE ☐ OTHER: _____ (SPECIFY)

SOURCE OF SAMPLE: _____

INDICATE SPECIFICALLY AS, TAP ON DISTRIBUTION SYSTEM, WELL, SPRING, RESERVOIR, ETC.

DATE SAMPLE COLLECTED: _____ 19____, AM ☐ PM ☐

ONE OF THESE REQUEST FORMS COMPLETELY FILLED OUT MUST ACCOMPANY EACH WATER SAMPLE SUBMITTED. ROUTINE WATER SAMPLES SHOULD BE COLLECTED ONLY ON SUCH DAYS AS WILL INSURE DELIVERY TO THE LABORATORY NOT LATER IN THE WEEK THAN THURSDAY. CARE SHOULD ALSO BE TAKEN TO AVOID DELIVERY ON HOLIDAYS.

DO NOT WRITE BELOW THIS LINE.

DATE RECEIVED: _____ 19____, AM ☐ PM ☐ DATE REPORTED: _____ 19____

RESULT

LAB. NO.	BACTERIA PER CC	GAS IN LACTOSE BROTH			COLI-AEROGES GROUP	EXAMINATION MADE BY
		10 CC	1 CC	0.1 CC		

REPORTED BY: _____

TENN. DEPT. OF PUBLIC HEALTH FORM 30

BACK

DIRECTIONS FOR COLLECTING WATER SAMPLE

1. Use only the regulation sterile bottle furnished by the Health Department for collecting the sample. This bottle has been specially cleaned and sterilized. Do not wash or clean it in any way.
2. Take sample as near as possible to time of departure of train on which sample is to be sent to the laboratory.
3. Do not remove the bottle from the mailing carton until ready to collect sample.
4. When ready to collect the sample, loosen the tinfoil which protects the stopper, but do not remove from the stopper. Remove stopper and protecting foil together, being very careful not to allow anything to touch the neck of the bottle or that portion of the stopper that goes into the bottle. Do not lay the stopper down, but hold in the hand until ready to replace in the bottle.
5. FAUCET: Allow water to run freely until the supply pipe has been flushed out completely from the main line, and in no case for less than five minutes.
6. PUMP: Operate the pump until the drop pipe has been flushed out completely, and in no case less than five minutes.
7. SPRINGS, STREAMS, and OPEN BODIES OF WATER: Fill the bottle by a forward scooping movement, moving the bottle upstream to prevent any wash from the hand entering the bottle. Bottle should be about three or four inches below the surface of the water, and the movement continuous until the bottle is nearly full and brought up out of the water.
8. Fill the bottle about three-fourths full, holding bottle near its base to prevent contamination.
9. Replace stopper and tinfoil immediately upon collection of the sample.
10. Fill out the information blank as indicated.

DIRECTIONS FOR MAILING WATER SAMPLE

1. Only mailing cartons furnished by the State Department of Public Health should be used, since these cartons insure a minimum of breakage and leakage.
2. Replace the bottle containing the sample in the mailing carton in the same manner as it was received.
3. Attach the addressed sticker, enclosed in the mailing carton, to the front side of the carton.
4. It is important that shipment be made promptly, since rapid changes may take place in water if left standing.
5. Sample will not be accepted by laboratory unless postage is prepaid.
6. This form filled out as indicated, with no other writing, complies with Sects. 568, 574 P. L. and R., and entitles user to enclose same with specimen for pouching with first-class mail at third or fourth-class postage rate, depending upon weight of parcel.

BACTERIOLOGICAL WATER EXAMINATION - FORM 603
SIZE 3½" x 6"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES MEMPHIS BRANCH LABORATORY				
BACTERIOLOGICAL WATER EXAMINATION				
LAB. NO. _____				
OWNER OF SUPPLY _____		DATE COLLECTED _____		
LOCATION OF SUPPLY _____		DATE RECEIVED _____		
COLLECTED BY _____		DATE REPORTED _____		
SOURCE OF SAMPLE _____				
		RESULT		
BACTERIA PER CC	GAS IN LACTOSE BROTH			COLI-AEROGENES GROUP
	10 CC	1 CC	0.1 CC	

*LOWER FIGURE SHOWS NUMBER OF LACTOSE TUBES INOCULATED, UPPER FIGURE SHOWS NUMBER OF TUBES IN WHICH GAS WAS PRODUCED. FOR INTERPRETATION OF THIS REPORT CONSULT YOUR CITY OR COUNTY HEALTH OFFICER.

TENN. DEPT. OF PUBLIC HEALTH FORM 603

DAIRY PRODUCTS TAG - FORM 604
SIZE 3" x 11"

DIVISION OF LABORATORIES				
SAMPLE NO. _____ (To be filled out by Analyst)	Sample No. _____	Lab. No. _____		
	Laboratory			
	Sample of _____	Rec'd _____	M _____	19 _____
	Dairy _____	Label _____		
	Time Collected _____	M _____	19 _____	Temp. at Collection _____ °F.
	Time Plated _____	M _____	19 _____	Temp. at Plating _____ °F.
	Sp. G. _____	B. F. _____	% S.N.F. _____	
	Standard Plate Count _____	Per ml. Phosphatase _____	Sediment _____	
	Inspector _____	City or County _____	Health Dept. _____	
	Analyst _____			
SAMPLE NO. _____ (To be retained by Inspector after recording "Time Collected" and "Temp. at Collection" on Lab. Card)	Sample No. _____	Lab. No. _____		
	Dairy			
	Distributor _____	Producer _____	Permit No. _____	
	Collected _____	M _____	19 _____	Temp. at Collection _____ °F.
	Collected by _____	Inspector _____		
	Notice given by Health Dept. _____	19 _____		
	Remarks: _____			
	(To be retained by Inspector after recording "Time Collected" and "Temp. at Collection" on Lab. Card)			
	Tenn. Dept. of Public Health Form No. 604			

DO NOT BE REMOVED FROM BOTTLE

DO NOT BE HELD BY DAIRYMAN OR DISTRIBUTOR

BACTERIOLOGICAL MILK EXAMINATION REPORT - FORM 605
SIZE 7" x 6"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH
DIVISION OF LABORATORIES

BACTERIOLOGICAL MILK EXAMINATION REPORT

FROM CITY OF _____, TENN. DATE COLLECTED _____

COLLECTED BY OR FOR _____ DATE RECEIVED _____

TEMPERATURE WHEN PLATED _____°F DATE REPORTED _____

[illegible]

Page 607 missing

MISCELLANEOUS REPORT FORM - FORM 606
SIZE 3½" x 6"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE		
LAB. NO. _____	MISCELLANEOUS REPORT FORM	
PATIENT'S NAME _____	ADDRESS _____	DATE _____
THE EXAMINATION RESULT ON THE SPECIMEN OF _____ SUBMITTED UNDER THE ABOVE NAME WAS _____ FOR _____		
TENN. DEPT. OF PUBLIC HEALTH FORM 606		

REPORT OF EXAMINATION FOR GONOCOCCI - FORM 608
SIZE 3½" x 6"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE		
LAB. NO. _____	REPORT OF EXAMINATION FOR GONOCOCCI	
PATIENT'S NAME _____	ADDRESS _____	DATE _____
EXAMINATION OF SMEAR SHOWED: (X DENOTES EXAMINATION FINDINGS)		
<input type="checkbox"/> GRAM NEGATIVE INTRACELLULAR DIPLOCOCCI FOUND MORPHOLOGICALLY RESEMBLING GONOCOCCI		
<input type="checkbox"/> GRAM NEGATIVE EXTRACELLULAR DIPLOCOCCI FOUND MORPHOLOGICALLY RESEMBLING GONOCOCCI		
<input type="checkbox"/> NO GRAM NEGATIVE DIPLOCOCCI FOUND MORPHOLOGICALLY RESEMBLING GONOCOCCI		
PUS CELLS WERE PRESENT <input type="checkbox"/> NOT PRESENT <input type="checkbox"/>		
TENN. DEPT. OF PUBLIC HEALTH FORM 608		

REPORT OF EXAMINATION FOR TUBERCLE BACILLI - FORM 609
SIZE 3½" x 6"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE REPORT OF EXAMINATION FOR TUBERCLE BACILLI		
_____ LAB. NO.		
_____ PATIENT'S NAME	_____ ADDRESS	_____ DATE
THE EXAMINATION RESULT ON THE SPECIMEN OF SPUTUM SUBMITTED UNDER THE ABOVE NAME WAS _____ FOR ACID FAST ORGANISMS MORPHOLOGICALLY RE- SEMBLING TUBERCLE BACILLI.		
TENN. DEPT. OF PUBLIC HEALTH FORM 609		

BACK

A diagnosis of pulmonary tuberculosis can usually be made from the history and physical examination, including X-ray, before the appearance of tubercle bacilli in the sputum.

A negative laboratory report means that tubercle bacilli were not found in the particular specimen submitted, and is not an absolute indication that the patient does not have tuberculosis. If the clinical evidence warrants, additional specimens should be examined.

PRE-MARITAL SEROLOGICAL TEST - FORM 610
SIZE 3½" x 6"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH

PRE-MARITAL SEROLOGICAL TEST

DIVISION OF LABORATORIES

LABORATORY NUMBER		NAME OF LABORATORY		
NAME	AGE	SEX	COLOR	DATE
ADDRESS		COUNTY		
THE EXAMINATION RESULT ON THE SPECIMEN SUBMITTED UNDER THE ABOVE NAME WAS				

THE PHYSICIAN SHOULD NOT REGARD THIS REPORT AS DIAGNOSTIC WITHIN ITSELF BUT SHOULD CONSIDER IT ONLY
AS A VALUABLE ADJUNCT TO THE HISTORY AND CLINICAL MANIFESTATIONS. (SEE REVERSE SIDE.)
TENN. DEPT. OF PUBLIC HEALTH FORM 610

BACK

A Positive Report is only one link in the chain of evidence to be used in making a diagnosis of syphilis. In the absence of clinical evidence of the disease additional specimens should be submitted.

Infectious mononucleosis, malaria and certain other conditions may give a positive serologic reaction.

All cases of syphilis should be reported on the special venereal disease report form.

A Negative Report means only that the particular specimen received failed to give positive results in a careful laboratory test. It does not necessarily rule out the disease condition suspected in the patient from whom the specimen was obtained. Where the clinical evidence indicates additional specimens should always be submitted.

A Doubtful Report may mean (1) that the disease condition has not progressed to the point necessary to produce sufficient reagin for a positive result; (2) that the reagin content of the blood is being affected by treatment; (3) that some unrelated condition is giving a non-specific reaction. Where the clinical evidence indicates additional specimens should be submitted.

SEROLOGIC TEST FOR SYPHILIS (DUPLICATE) - FORM 610-2
SIZE 3½" x 6"

FRONT

**WRITE PLAINLY
DO NOT DETACH**

SPECIMEN WILL NOT BE EXAMINED UNLESS THIS FORM IS SUBMITTED

**TENNESSEE DEPARTMENT OF PUBLIC HEALTH
SEROLOGIC TEST FOR SYPHILIS**

NAME _____ AGE _____ SEX _____ COLOR _____
 ADDRESS _____ COUNTY _____
 DATE COLLECTED _____ SPECIMEN OF BLOOD ☐ SPINAL FLUID ☐ IF PREMARITAL CHECK HERE ☐

PERSON SUBMITTING SPECIMEN MUST NOT WRITE IN THIS SPACE

DATE RECEIVED _____ DATE REPORTED _____
 LABORATORY NUMBER _____ RESULT _____

 REPORT IS NOT OFFICIAL WITHOUT THIS SIGNATURE _____

DR. _____ NAME _____
 REPORT TO _____
 STREET OR R. F. D. ADDRESS _____
 CITY AND STATE _____

☐ PATENTED

ORIGINAL TO BE RETAINED BY LABORATORY PERFORMING TEST

FORM 610-2

BACK

INSTRUCTIONS

BLOOD: Submit 5-10 cc. of blood for agglutination, or serologic test for syphilis. This blood should be collected aseptically and submitted in the sterile container provided for this purpose. The specimen should not be obtained within an hour after the patient has eaten since chylous blood is unsatisfactory for examination.

Collect the blood with a clean, dry, sterile needle and syringe. A wet or contaminated needle or syringe will cause hemolysis of the specimen. A hemolyzed or grossly contaminated specimen is unsatisfactory for examination. As soon as the blood has been put in the sterile container, place the container in a slanting position until the blood clots.

In warm weather the time between collection and the time the specimen reaches the laboratory should be held to a minimum since exposure to temperatures over 50°F. will hasten hemolysis. It is preferable to place the specimen in an ice-box (do not freeze) until just before it is to be mailed or carried to the laboratory.

SPINAL FLUID: Submit at least 5 cc. of an uncontaminated specimen of spinal fluid for a serologic test for neuro-syphilis in the container provided for this purpose. Spinal fluid containing blood should not ordinarily be submitted for examination. If the blood serology of a patient is positive, the blood in a blood contaminated specimen of spinal fluid will cause a false positive reaction.

RESULT

A **Positive Report** is only one link in the chain of evidence to be used in making a diagnosis of syphilis. In the absence of clinical evidence of the disease additional specimens should be submitted.

Infectious mononucleosis, malaria and certain other conditions may give a positive serologic reaction.

All cases of syphilis should be reported on the special venereal disease report form.

A **Negative Report** means only that the particular specimen received failed to give positive results in a careful laboratory test. It does not necessarily rule out the disease condition suspected in the patient from whom the specimen was obtained. Where the clinical evidence indicates additional specimens should always be submitted.

A **Doubtful Report** may mean (1) that the disease condition has not progressed to the point necessary to produce sufficient reagin for a positive result; (2) that the reagin content of the blood is being affected by treatment; (3) that some unrelated condition is giving a non-specific reaction. Where the clinical evidence indicates additional specimens should be submitted.

SEROLOGIC TEST FOR SYPHILIS (TRIPLICATE) - FORM 610.3
 SIZE 3½" x 6"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH
 SEROLOGIC TEST FOR SYPHILIS

NAME _____ AGE _____ SEX _____ COLOR _____
 ADDRESS _____ COUNTY _____
 DATE COLLECTED _____ SPECIMEN OF BLOOD ☐ SPINAL FLUID ☐ IF PREMARITAL CHECK HERE ☐

PERSON SUBMITTING SPECIMEN MUST NOT WRITE IN THIS SPACE

DATE RECEIVED _____ DATE REPORTED _____
 LABORATORY NUMBER _____ RESULT _____

REPORT IS NOT OFFICIAL WITHOUT THIS SIGNATURE _____

DR. _____ NAME _____

REPORT
 TO

STREET OR R. F. D. ADDRESS _____

CITY AND STATE _____

ORIGINAL TO BE RETAINED BY LABORATORY PERFORMING TEST

FORM 610-3

WRITE PLAINLY
 DO NOT DETACH

SPECIMEN WILL NOT BE EXAMINED UNLESS THIS FORM IS SUBMITTED

☐ PATENTED

BACK

INSTRUCTIONS

BLOOD: Submit 5-10 cc. of blood for agglutination, or serologic test for syphilis. This blood should be collected aseptically and submitted in the sterile container provided for this purpose. The specimen should not be obtained within an hour after the patient has eaten since chylous blood is unsatisfactory for examination.

Collect the blood with a clean, dry, sterile needle and syringe. A wet or contaminated needle or syringe will cause hemolysis of the specimen. A hemolyzed or grossly contaminated specimen is unsatisfactory for examination. As soon as the blood has been put in the sterile container, place the container in a slanting position until the blood clots.

In warm weather the time between collection and the time the specimen reaches the laboratory should be held to a minimum since exposure to temperatures over 50 F. will hasten hemolysis. It is preferable to place the specimen in an ice-box (do not freeze) until just before it is to be mailed or carried to the laboratory.

SPINAL FLUID: Submit at least 5 cc. of an uncontaminated specimen of spinal fluid for a serologic test for neuro-syphilis in the container provided for this purpose. Spinal fluid containing blood should not ordinarily be submitted for examination. If the blood serology of a patient is positive, the blood in a blood contaminated specimen of spinal fluid will cause a false positive reaction.

RESULT

A **Positive Report** is only one link in the chain of evidence to be used in making a diagnosis of syphilis. In the absence of clinical evidence of the disease additional specimens should be submitted.

Infectious mononucleosis, malaria and certain other conditions may give a positive serologic reaction.

All cases of syphilis should be reported on the special venereal disease report form.

A **Negative Report** means only that the particular specimen received failed to give positive results in a careful laboratory test. It does not necessarily rule out the disease condition suspected in the patient from whom the specimen was obtained. Where the clinical evidence indicates additional specimens should always be submitted.

A **Doubtful Report** may mean (1) that the disease condition has not progressed to the point necessary to produce sufficient reagin for a positive result; (2) that the reagin content of the blood is being affected by treatment; (3) that some unrelated condition is giving a non-specific reaction. Where the clinical evidence indicates additional specimens should be submitted.

AGGLUTINATION TEST REPORT • FORM 611
SIZE 3½" x 6"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES CENTRAL LABORATORY, NASHVILLE AGGLUTINATION TEST REPORT		
_____ LAB. NO.		
_____ PATIENT'S NAME		
_____ ADDRESS		_____ DATE
MACROSCOPIC AGGLUTINATION RESULTS ON THE SPECIMEN OF BLOOD SUBMITTED UNDER THE ABOVE NAME WERE AS FOLLOWS:		
TYPHOID _____ TULAREMIA _____		
PROTEUS X19 _____		
UNDULANT FEVER _____		
<div style="position: relative;"> <div style="position: absolute; top: 0; left: 0; width: 100%; height: 100%; border: 1px solid black;"></div> </div>		
TENN. DEPT. OF PUBLIC HEALTH FORM 611		

BACK

All blood specimens received for agglutination are routinely tested against typhoid, proteus X19, undulant fever and tularemia antigens employing 1:40, 1:80, 1:160, 1:320 and 1:640 dilutions of the serum. Results are reported as:

1. **NEGATIVE**—No agglutination in any dilution.
2. **PARTIAL**—Where complete agglutination does not take place in any dilution incomplete agglutination is reported in the highest dilution in which it occurs.
3. **COMPLETE**—Complete agglutination through the dilution indicated.

Agglutinating antibodies are frequently not demonstrable before the second week of a disease and in some instances may not appear until after the patient has clinically recovered.

Where typhoid or paratyphoid is suspected a blood culture should be submitted at the earliest possible time in the special culture bottle (with preservative) provided by the laboratory. Most positive blood cultures are obtained during the first ten days of the disease.

LABORATORY FORMS . FORMS 600, 602, 603,
604, 605, 606, 608, 609, 610, 610-2, 610-3, 611

600)
602)
603)
604)
605)
606)
608)
609)
610)
610-2)
610-3)
611)

PURPOSE: To provide the laboratory with necessary identifying data for test or examination desired, and with supplementary information as to source of material.

To provide the health department and the private physician with results of laboratory examinations.

EXPLANATION AND DEFINITIONS: Data required on identifying form accompanying specimen to the laboratory are self-explanatory. Such data should be supplied in all cases.

USED BY: The person sending specimen to laboratory for examination, and persons handling reports of results which include personnel of local health departments and private physicians.

OFFICE MECHANICS AND FILING: Laboratory forms are made out and sent with the specimen to the laboratory. The laboratory sends reports to the local health department, and also sends reports to the private physicians when indicated. The results of laboratory examinations are transferred to individual records of patients when such records have been opened. Reports from the laboratory are filed alphabetically by type of test; reports for the current month may be kept together until end of month.

COMMENT: Particular care should be exercised to see that the proper request form accompanies each specimen submitted to the laboratory. Instructions are given on the back of the forms.

Pages 612-619 missing

REQUISITION FOR LABORATORY SUPPLIES - FORM 620
SIZE 11" x 8½"

TENNESSEE DEPARTMENT OF PUBLIC HEALTH
DIVISION OF LABORATORIES

REQUISITION FOR LABORATORY SUPPLIES

SEND TO _____

ADDRESS _____

BIOLOGICS	NUMBER	CONTAINERS	NUMBER
DIPHTHERIA TOXIOD, ALUM PRECIPITATED, 10 ML. VIALS	_____	INDIVIDUAL BLOOD	_____
DIPHTHERIA TOXIN (SCHICK TEST) 5 ML. VIALS	_____	MULTIPLE BLOOD (5)	_____
		MULTIPLE BLOOD (10)	_____
DISTILLED WATER		DIPHTHERIA CULTURE	_____
100 ML. BOTTLES	_____		
250 ML. BOTTLES	_____	ENTERIC CULTURE, BLOOD	_____
PHENOLIZED PHYSIOLOGIC SALINE, 250 ML. BOTTLES	_____	ENTERIC CULTURE, FECES AND URINE	_____
PHYSIOLOGIC SALINE		INTESTINAL PARASITES	_____
250 ML. BOTTLES	_____		
PROCAINE HYDROCHLORIDE		SLIDES FOR G.C. AND MALARIA	_____
25 ML. BOTTLES	_____		
250 ML. BOTTLES	_____	SPUTUM, MICROSCOPIC	_____
SILVER NITRATE AMPULES		SPUTUM, CULTURE*	_____
BOXES (4 AMPULES TO BOX)	_____	RH TYPING* (INDIVIDUAL)	_____
TYPHOID VACCINE		RH TYPING* (MULTIPLE)	_____
25 ML. BOTTLES	_____		
100 ML. BOTTLES	_____	STREPTOCOCCUS CULTURES*	_____
250 ML. BOTTLES	_____		
TRIPLE TYPHOID VACCINE		*SERVICE AVAILABLE IN CENTRAL LABORATORY ONLY.	
25 ML. BOTTLES	_____		
100 ML. BOTTLES	_____	REQUEST FORMS	
MISCELLANEOUS:		MISCELLANEOUS, FORM 600	_____
_____		WATER, FORM 602	_____
_____		DAIRY PRODUCTS TAG, FORM 604	_____
_____		SEROLOGIC, FORM 610-2(2-PART)	_____
_____		SEROLOGIC, FORM 610-3(3-PART)	_____
_____		REQUISITION FOR LABORATORY SUPPLIES, FORM 620	_____

DATE

SIGNATURE

SUBMIT TO LABORATORY IN DUPLICATE. BE SPECIFIC IN ORDERING. RETURN ALL CONTAINERS, BOTTLES, VIALS, STOPPERS AND BOXES TO LABORATORY.

REQUISITION FOR LABORATORY SUPPLIES - FORM 620

PURPOSE: To serve as an order sheet for laboratory materials commonly furnished free to local health departments and physicians by the Division of Laboratories, Tennessee Department of Public Health.

EXPLANATION AND DEFINITIONS: Type of record: Requisition form for laboratory supplies.

USED BY: Physicians in unorganized counties, and local health departments in organized counties.

OFFICE MECHANICS AND FILING: Requisitions are made in triplicate; one copy is retained in the local health department, the original and one copy are sent to laboratory serving the area. The original of the requisition will be checked as filled, dated and initialed by the shipping clerk when shipped, and filed in the laboratory for at least fifteen months from date of shipment. The copy of this requisition will be checked as filled and enclosed with the shipment as a shipping ticket.

9-20-48

Pages 621-905 missing

MASS X-RAY SURVEY EXAMINATION RECORD - FORM 905
SIZE 4½" x 7¼"

FIRST SHEET

TO REMOVE CARBONS

Bend and fold stub back all the way Grasp staggered loose ends firmly Hold loose ends firmly and unbend stubs Give few easy jerks, then a quick snap

MASS X-RAY SURVEY EXAMINATION RECORD

COUNTY OF EXAMINATION: _____		NAME OF PLANT, GROUP, ETC.: _____			
FAMILY PHYSICIAN: _____		NAME _____		ADDRESS _____	
COUNTY OF RESIDENCE: _____		COLOR: _____	SEX: _____	AGE: _____	
1. <input checked="" type="checkbox"/> NEGATIVE X-RAY	NAME: _____				
2. <input type="checkbox"/> REPORT TO PHYSICIAN	(MR., MISS, MRS.)		FIRST	MIDDLE	LAST
3. <input type="checkbox"/> UNSATISFACTORY FILM	ADDRESS: _____				
		CITY AND STATE: _____			
TUBERCULOSIS			NON-TUBERCULOSIS CHEST PATHOLOGY		
NEGATIVE: _____	MINIMAL: _____	ACTIVE: _____	PNEUMOCONIOSIS: _____	LUNG ABSCESS: _____	TUMOR: _____
SUSPICIOUS: _____	MOD. ADV.: _____	QUEST. ACT.: _____	PROBABLE: _____	BRONCHITIS: _____	OTHER: _____
FIRST INFECT: _____	FAR ADV.: _____	INACTIVE: _____	PLEURAL EFF.: _____	ABNORMAL HEART: _____	UNDETERM.: _____

ALLSET - M.D. BY THE EERY REGISTER CO., PATENTED

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 905

CARBON

TO REMOVE CARBONS

Bend and fold stub back all the way Grasp staggered loose ends firmly Hold loose ends firmly and unbend stubs Give few easy jerks, then a quick snap

Date: _____

The x-ray of your chest made on the above date showed no evidence of tuberculosis at that time. This does not mean that tuberculosis cannot develop at some later date.

Every adult should have an x-ray once a year.

Sec. 562, P. L. and R.
U. S. POSTAGE
Paid
Nashville, Tenn.
Permit No. 434

IMPORTANT-KEEP THIS CARD

The above number is the number on the X-RAY film made of your chest and is the only means of locating your record. A report of your examination will be mailed to you, but if you fail to receive your report within four (4) weeks, write to:

Division of Tuberculosis Control
BEN ALLEN ROAD
NASHVILLE, 7, TENNESSEE

BE SURE TO GIVE ABOVE NUMBER AND
CORRECT MAILING ADDRESS WHEN
YOU WRITE.

ALLSET - M.D. BY THE EERY REGISTER CO., PATENTED

BACK

The Division of Tuberculosis Control of the Tennessee Department of Public Health offers a free x-ray examination of the chest to each person 15 years of age and over, once a year. One of the mobile units from the Division will visit your county again next year and you are invited to come in for another examination at that time.

Division of Tuberculosis Control
Tennessee Department of Public Health

PURPOSE: To provide a record of persons given x-ray examinations in a mass survey by use of small film.

EXPLANATION AND DEFINITIONS: This record, composed of three parts, replaces records 901, 902 and 905 formerly used in the survey work. Part one (the first sheet) of this record is similar to the former record 905 and becomes a permanent x-ray record. The small perforated section in part two (the carbon copy) is given to the individual at the time of x-ray and replaces form 901. The remainder of part two is a postal card addressed to the individual and is mailed as a report on his examination.

USED BY: Division of Tuberculosis Control, and local health department personnel.

OFFICE MECHANICS AND FILING: After these records have been used in the Division of Tuberculosis Control, they will be returned to the counties for their information. The records may be checked against case and contact records in the files and notations made on these records of results of examinations made in the survey. A person with a diagnosis of tuberculosis on a 14 x 17 inch film who is called negative on a small film should continue to be carried as a case of tuberculosis. The survey records may be filed alphabetically either in a separate file or behind the regular records in the x-ray report file.

Since the county receives X-ray Report - Small Film, Form 906, for persons found to have pathology on small films, Form 905 for these persons may be destroyed. In that event, the file of persons examined in the survey will include only those with a negative diagnosis.

X-RAY REPORT - SMALL FILM - FORM 906
SIZE 5" x 8"

FRONT

X-RAY REPORT - SMALL FILM

Name _____ Date _____ County _____
Address _____ City _____ Color _____ Sex _____ Age _____
Physician _____ Address _____
Place of Examination (Name of Plant, etc.) _____
Former Diagnosis _____ Date _____
X-Ray Number _____ Film Size _____
Diagnosis:

Tenn. Dept. Public Health 906
Division of Tuberculosis Control

BACK

CLASSIFICATION

BY EXTENT: (DOES NOT REFER TO SYMPTOMS)

MINIMAL

NO CAVITY FORMATION. MAY INVOLVE ONE OR BOTH LUNGS. TOTAL AMOUNT OF INVOLVEMENT DOES NOT EXCEED VOLUME OF LUNG TISSUE FOUND IN ONE LUNG ABOVE SECOND RIB IN FRONT AND FOURTH VERTEBRAL SPINE BEHIND.

MODERATELY ADVANCED

MAY OR MAY NOT HAVE CAVITY FORMATION—TOTAL DIAMETER ON CAVITIES DOES NOT EXCEED FOUR CM. MAY OR MAY NOT INVOLVE BOTH LUNGS, BUT DOES NOT EXCEED VOLUME OF ONE-THIRD OF ONE LUNG IF A LARGE LESION OR VOLUME OF ONE LUNG IF SCATTERED SMALL LESIONS.

FAR ADVANCED

MORE EXTENSIVE LESIONS THAN MODERATELY ADVANCED OR GREATER CAVITY FORMATION.

BY ACTIVITY: (BASED ON X-RAY AND SYMPTOMS)

ACTIVE

CONSTITUTIONAL SYMPTOMS PRESENT
EVIDENCE OF PROGRESSIVE LESION ON X-RAY

INACTIVE

NO CONSTITUTIONAL SYMPTOMS
EVIDENCE OF STATIONARY OR RETROGRESSIVE LESIONS ON X-RAY.

X-RAY REPORT - SMALL FILM - FORM 906

PURPOSE: To report to the local health officer and private physicians the diagnosis and objective description of the x-ray film of a person examined with photoroentgenographic equipment (4 by 5 inch or 70 mm.) who was thought to have pathology (tuberculous or non-tuberculous).

EXPLANATION AND DEFINITIONS: This record is printed on paper of a distinctive color (salmon) so that it will be readily distinguishable from x-ray reports of persons examined with 14 by 17 inch films.

Items on record (with one exception) correspond to items on the card made out for each person at the time of examination on the mobile unit or with 70 mm. equipment. For a person with pathology the information on the examination card is transferred to this record in the Division of Tuberculosis Control, the x-ray reading and former diagnosis added, and copies of the report forwarded to the local health officer and to the private physician of the patient.

The items "former diagnosis" and "date" cannot always be completed in the Division of Tuberculosis Control. In this case, this information should be added to the record by the clerk.

USED BY: Health officer, nurse, and clerk.

OFFICE MECHANICS AND FILING: When these reports are received, the clerk should check them against the x-ray report file and enter the former diagnosis of persons previously examined. The reports should then go to the health officer and the nurses for their information and use. The records should be returned to the clerk for filing in x-ray report file.

Pages 907-909 missing

BACK

TUBERCULOSIS CLINIC ORGANIZATION SHEET

COUNTY _____ PLACE OF CLINIC _____ DATE OF CLINIC _____

[illegible]

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 910

PURPOSE: To provide a list of appointments made, type of referral and name and relationship of contact (if examined because of contact), and to distribute appointments evenly over the clinic session.

EXPLANATION AND DEFINITIONS:

New or Old: This item is designed to distinguish between persons examined for the first time (new) and persons reporting for reexamination (old).

Contact: If the person is referred because of contact, or known to be a contact, to a known case of tuberculosis, the name of that case and his relationship to the person being examined should be stated here. This information should be recorded on this sheet by the nurse or clerk when she enters the name of the person to be examined. This will give the desired information to the nurse holding the clinic.

Type of Case: This refers to the type of case of the contact, whether fatal, sputum positive, or other.

USED BY: Nurse and clerk.

OFFICE MECHANICS AND FILING: As the nurse refers patients to the clinic she lists the name and other data on this form. When a private physician calls to refer a patient for examination at the clinic, the name and address, etc., of the patient are listed here. The clerk sends out notices from this list one week prior to the date of the clinic.

"After the clinic, the examination records should be checked against this sheet in order to record those keeping and not keeping appointments. These sheets should be kept for reference in planning future clinics.

11-3-47

Page 911 missing

X-RAY EXAMINATION RECORD - FORM 912

SIZE 5" x 8"

FRONT

X-RAY EXAMINATION RECORD				Exam. Number: _____
Name: _____	Date: _____	County of Exam.: _____		Resident County: _____
Address: _____	Community: _____	Color: _____	Sex: _____	Age: _____
Physician: _____	Address: _____			
Reason for X-ray: (State contacts and symptoms) _____				

Date and Results of Sputum Examinations: _____				
Former Diagnosis:	<div style="display: inline-block; vertical-align: middle;"> { Small Film: _____ 14"x 17" Film: _____ </div>	Size of film: _____	Date: _____	X-ray No.: _____
			Date: _____	X-ray No.: _____
Present X-ray No.: _____ Machine No.: _____ Technique Used: _____ Recommended Change: _____				
Present Diagnosis: _____				

Tenn. Dept. of Public Health 912
 Division of Tuberculosis Control

BACK

CLASSIFICATION	
<p style="text-align: center;">BY EXTENT: (DOES NOT REFER TO SYMPTOMS)</p> <p>MINIMAL</p> <p>NO CAVITY FORMATION. MAY INVOLVE ONE OR BOTH LUNGS. TOTAL AMOUNT OF INVOLVEMENT DOES NOT EXCEED VOLUME OF LUNG TISSUE FOUND IN ONE LUNG ABOVE SECOND RIB IN FRONT AND FOURTH VERTEBRAL SPINE BEHIND.</p> <p>MODERATELY ADVANCED</p> <p>MAY OR MAY NOT HAVE CAVITY FORMATION—TOTAL DIAMETER ON CAVITIES DOES NOT EXCEED FOUR CM. MAY OR MAY NOT INVOLVE BOTH LUNGS, BUT DOES NOT EXCEED VOLUME OF ONE-THIRD OF ONE LUNG IF A LARGE LESION OR VOLUME OF ONE LUNG IF SCATTERED SMALL LESIONS.</p> <p>FAR ADVANCED</p> <p>MORE EXTENSIVE LESIONS THAN MODERATELY ADVANCED OR GREATER CAVITY FORMATION.</p>	<p style="text-align: center;">BY ACTIVITY: (BASED ON X-RAY AND SYMPTOMS)</p> <p>ACTIVE</p> <p>CONSTITUTIONAL SYMPTOMS PRESENT EVIDENCE OF PROGRESSIVE LESION ON X-RAY</p> <p>INACTIVE</p> <p>NO CONSTITUTIONAL SYMPTOMS EVIDENCE OF STATIONARY OR RETROGRESSIVE LESIONS ON X-RAY.</p>

X-RAY EXAMINATION RECORD - FORM 912

PURPOSE: For use in tuberculosis clinics conducted by the Tennessee Department of Public Health.

EXPLANATION AND DEFINITIONS: This record is a combination clinic record and x-ray report. It is printed in two colors (blue and white) to distinguish between the records of those with previous x-ray reports in the files and of those without previous records.

The white form is to be used when no previous x-ray record has been filed. The following groups are given a white record:

- (1) Persons in routine health department clinics having first x-ray examination of any kind under the State program.
- (2) Persons in routine health department clinics previously diagnosed as negative on small film and for whom no X-ray Report - Small Film, Form 906, was made. Examination number would be 2, 3 etc., including small film examinations.

The blue form is to be used for those individuals with other x-ray reports on file. A blue record is used for the following groups:

- (1) Persons in routine health department clinics having 2nd, 3rd, etc., x-ray examination on large film in a routine health department clinic.
- (2) Persons in routine health department clinics having had diagnoses of some pathology on small film. For these people, x-ray records, X-ray Report - Small Film, Form 906, will be on file. These examinations should be numbered 2, 3 etc., including small film examinations.
- (3) Persons in routine health department clinics for first time who have been hospitalized in a state hospital and for whom hospital summary records are in the county file. Examination would be numbered one.

Reason for X-ray: For completion of the reason for x-ray, the individual is to be questioned regarding contact with tuberculosis, symptoms and onset of disease. The type of information desired is given below:

Contact - If the individual being x-rayed has had household or frequent visiting contact with a tuberculosis patient, state relationship of tuberculosis case to contact. If individual is being examined because of contact and does not have any symptoms, state this on the record. As long as individual is considered negative repeat contact history each time examined.

Symptoms - The present illness is to be described with date and nature of onset, symptoms of tuberculosis as cough, fatigue, blood spitting, etc., making note of any changes in symptoms since last x-ray. Specify treatment for tuberculosis, with dates of operations, etc. State if disabled and amount of bed rest taken at present.

Example - Mother, Mary Doe, died from tuberculosis in 1943. Patient had pneumonia in November, 1946, and has continued to cough, tires easily and has lost 10 lbs. in last four weeks.

Examination on Survey - If the individual being x-rayed has had no symptoms of, or contact with, tuberculosis but is admitted to the clinic because of an examination on a small film, this fact should be stated. Example: No symptoms, no contact. Examined in Cookeville Public Survey.

Sputum Examinations: The dates and results of the last sputum examinations are added at the time the examination record is prepared. For persons without field records, the dates and results of sputum examinations are recorded on this record, Form 912.

USED BY: Health officer, nurse, clerk, technician and clinician.

OFFICE MECHANICS AND FILING: It is suggested that the nurse, clerk and technician complete a temporary record for office use during the clinic and that the nurse obtain the reason for x-ray, the contacts and symptoms. The technician is to add the x-ray number and technique. The information is then typed in quadruplicate, or if resident county is different from the county of examination, then five copies are made. All copies are mailed to the Division of Tuberculosis Control for recording of interpretations of x-ray film. Two copies, or in the case where resident county is different from county of examination, three copies, are returned to the local health department. One of these forms is sent immediately to the family physician by the clerk of the health department, while a second copy is retained in the office of the local health department. If three copies are received, the third copy is sent to the local health department of the county in which the patient lives, or, if that county does not have a local health department, the copy is sent to the Division of Tuberculosis Control with the notation - *Attention, Field Nurse*. The temporary record should be destroyed after the typed forms have been returned.

The typed record retained in the local health department is to go to the health officer and nurse for their information. A Tuberculosis Record, Form 920, is to be prepared for each reinfection type case. If coded for reexamination, a tickler card would be prepared. If the individual examined is a contact, the result of examination should be recorded on the Tuberculosis Record, Form 920, in the space provided for this contact under "Members of Family and Contacts".

After the record has been used, it is to be filed alphabetically with other x-ray reports and kept indefinitely. The reexamination record (blue) is to be attached to and placed in front of the previous x-ray reports of the individual.

COMMENT: In ordering this record specify the color desired; i.e., Form 912, White will be ordered for first examinations, and Form 912, Blue for reexaminations.

Pages 913-919 missing

SIZE 10" x 8"

TUBERCULOSIS RECORD

Date Referred to Rehabilitation	Remarks
---------------------------------	---------

TUBERCULOSIS RECORD

Name _____

LAST NAME

FIRST NAME

Date	Temperature		Pulse	Cough	Night Sweats	Hemoptysis		Appetite	Weight	Sleeps Alone	Sneezing Quarters	Care of Utensils	Sputum			Rest	Diet	Number Medical Conference Visits	Worker
	Time	Reading				Amount	Date						Amount	Disposal	Number Expectorators Left				

DATE _____

SUPPLEMENTAL FACTS

WORKER

[illegible]

Code: 0. Satisfactory; 1, 2, 3, slightly, moderately or markedly unsatisfactory; — no information obtained.

TUBERCULOSIS RECORD - FORM 920

PURPOSE: To provide epidemiological and clinical data and record of field observations (visits) of cases of tuberculosis of reinfection type.

EXPLANATION AND DEFINITIONS:

Reported by: Source of report - physician, clinic, veterans hospital, etc. - is given here.

Date Diagnosis Received: Date reported by private physician, date diagnosis received from the Division of Tuberculosis Control, or date reported by other agency.

Date investigated: Date first visited by health officer or nurse.

Education: School and grade completed.

History of Illness: Record here the nature and date of onset of tuberculosis. Summarize symptoms from onset of disease to present.

Clinic or Physician's Report: Diagnosis of private physician, hospital, veterans hospital, or the Division of Tuberculosis Control, etc.

Sputum Analysis: Record from laboratory slips results of sputum analyses. For other tests, such as tuberculin, record results.

Physician's Orders: Intended for recording physician's written orders and refers to such facts in the history or in present condition of case as attending physician deems it necessary to furnish to nurse for her guidance.

Previous Medical Care: Summarize medical care for tuberculosis received prior to date reported to local health department.

Summary of Hospitalization: Information concerning any known hospitalization should be recorded in this space (including summaries of hospitalization received from tuberculosis hospitals). This refers to hospitalization since date of diagnosis. Any treatment received in hospital including pneumothorax, phrenic crush, etc., should be stated here.

Other Treatment And Care: This refers to special treatment received in addition to that received as an admitted patient in the hospital such as treatment received in a clinic, private physician's office or in out-patient department of a hospital, etc. Record of continuation of pneumothorax initiated in hospital or physician's office should be made here. Date treatment instituted and date discontinued should be noted.

Vocational Rehabilitation: Date referred to rehabilitation service of Department of Education with remarks regarding type of training desired, etc.

Family History of Tuberculosis and Exposure to Tuberculosis: Any known cases of tuberculosis or deaths from tuberculosis of persons with whom this case has been in contact.

Specify relationship of person with tuberculosis to case; as father, brother, child, boarder, etc.

Date began and date ended refer to dates of contact with the person when he had tuberculosis.

Type of case refers to active, inactive or fatal.

Members Of Family And Contacts: List here in order the parents, siblings (brothers and sisters), consort (husband or wife), and children of case.

Effort should be made to secure examination of all these living relatives, irrespective of present household. In addition, all household contacts should be listed and examined irrespective of relationship.

Record of Field Observations (Visits): The coding system of the third and fourth pages is intended for use by the health officer or nurse in making visits to provide current information on the patient and on control measures. Code is used for *cough, night sweats, appetite, weight*, (actual weight is recorded for ambulant patient), *sleeping quarters, care of utensils, sputum disposal, rest and diet*.

Also record here information from the x-ray examination record, such as temperature, pulse, weight, etc., as may be available and indicate that this information was obtained at the clinic by substituting the word, "clinic" for "worker".

Supplemental Facts: Provided for record of observations (visits) by health officer and nurse.

Single continuation sheets are to be attached as needed.

OFFICE MECHANICS AND FILING: This record is to be opened by the health officer or nurse on the date investigated. Record is used for cases of reinfection type of tuberculosis. The record is indexed by clerk and filed in the family folder.

11-3-47

TUBERCULOSIS RECORD - SUPPLEMENT - FORM 920-B
SIZE 10" x 8"

[illegible]

COMMENT: This sheet is used to provide additional space for recording reports of x-ray examinations, results of sputum analyses, etc. When used, the supplement is to be attached to front of the Tuberculosis Record, Form 920.

11-3-47

Pages 921-927 missing

REEXAMINATION INDEX - TUBERCULOSIS - FORM 928
SIZE 3" x 5"

REEXAMINATION INDEX—TUBERCULOSIS		
NAME	REEXAM. DATE	
ADDRESS	COLOR	AGE
IF CHILD, PARENT'S NAME		
CONTACT TO TUBERCULOSIS (NAME)		
DIAGNOSIS	DATE	
CODE	SPUTUM ANALYSIS	
APPOINTMENT GIVEN: DATE	EXAM.	
DATE		

TENNESSEE DEPARTMENT OF PUBLIC HEALTH 928

PURPOSE: To provide a file of persons who should be reexamined but who may not need routine tuberculosis nursing service.

EXPLANATION AND DEFINITIONS:

This file may include the following:

1. Individuals with suspicious lesions.
2. Diagnosed cases considered inactive or of doubtful activity (whether coded for reexamination or not).
3. Individuals coded for reexamination because of non-tuberculous pathology.
4. Household contacts and family members (parents, brothers, sisters and children) of deceased cases, (whether coded for reexamination or not).

In the absence of a code, inactive cases should be listed for reexamination in accordance with schedule outlined in Procedures for Conducting the Tuberculosis Program.

It may prove helpful to schedule household contacts and family members of cases for reexamination through the Reexamination Index. For example, for a child under 15 years of age who has been examined once and found to be negative, one of these cards may be made out and dated as of the date the child becomes 15, when he should be picked up again for examination each year. The same procedure may be used for contacts and relatives in the age period when reexamination is necessary, whether or not they are coded for reexamination.

Contact to Tuberculosis (Name): Note here the names of cases to whom individual is related or is in contact, so that this information may be entered on Tuberculosis Clinic Organization Sheet, Form 910, direct from this card.

USED BY: Nurse and Clerk.

OFFICE MECHANICS AND FILING: When the x-ray reports are checked by the nurse, she should make out Reexamination Index Cards for persons coded for reexamination only. She may also make out cards for contacts and relatives not coded for reexamination who should be reexamined according to Procedures For Conducting the Tuberculosis Program. The cards are filed according to year and month in which individual is to be reexamined.

In working up clinics, the nurse pulls cards for persons due to be examined in a given month, selects cases to be notified of clinic date and lists name on the Tuberculosis Clinic Organization Sheet, Form 910. (Cases listed on the work sheet for reexamination in a given month and individuals referred by private physician usually take precedence over individuals carried in the Reexamination Index File). When clinic appointments cannot be given all individuals in this file, cards for those not to be examined are moved back to the next month and usually they take precedence over those in the reexamination file for the next month. The date that notice of clinic appointment is sent should be entered on this card. After an individual attends the clinic, the card is destroyed.

If two notices to attend clinic are ignored, the health officer should be consulted as to further contact with the individual. The date of notification might then be entered on the clinic record of the individual, near the code on the last examination, and the reexamination index card destroyed.

COMMENT: Since it is necessary to correlate the service to these individuals with that to cases carried by nurse and to individuals referred by physicians, the nurse should be responsible for keeping this file current.

In counties with case-contact registers, use of the reexamination index will be modified.

Example: R3VIS

Reexamination in three months

Visit once a month

Sputum analyses, not less than three specimens.

The code is used as a guide but is subject to the approval of the family physician. If the physician desires a reexamination before the coded time, the code would be disregarded. When no code is given, the schedule of examinations and nursing visits outlined in Procedures for Conducting the Tuberculosis Program is followed.

USED BY: It is the responsibility of the individual nurse to see that the work sheet is kept up-to-date. However, the health officer and other members of the organization should be cognizant of the tuberculosis problem in the county and should, therefore, be familiar with the sheet and the way it is used. The health officer should review it from time to time, in order that he may see how well the service is being rendered in his county.

OFFICE MECHANICS AND FILING: At the first of each calendar year, all active cases of tuberculosis and others needing nursing service should be listed on the "Tuberculosis Work Sheet", filling in spaces as indicated. Names should be arranged alphabetically with a few spaces between letters for new cases admitted. Indicate in the specific spaces provided for the months, the schedule of reexaminations, visits, and sputum analysis, thus R

V
S

These symbols are written with red ink or a red pencil to indicate the recommended service; the symbols are written with black ink when the service is rendered.

After each clinic is held, the x-ray reports are reviewed, new cases are added to the list and schedule of examinations and visits revised in accordance with changes in diagnoses and recommendations. It is suggested that the code and x-ray findings be recorded in pencil.

If the patient moves from the county, dies, or the diagnosis is definitely changed to inactive, notation is made as follows:

After name write: Moved, inactive, or dead; and in calendar section write: address to which the individual moved; final diagnosis, inactive, at clinic _____ (Date)
and if dead, write: died _____ (Date).

A line may be drawn through the names of patients who have died or removed from the county.

Page 930 missing

TUBERCULIN TEST CARD - FORM 931
SIZE 3" x 5"

Name		Age	
Last	First		
Address		District	Sex
		Color	
School		Parent's Name	
TUBERCULIN TEST			
DATE OF TEST	AMOUNT	RESULT	
	mg.		
	mg.		
	mg.		

Tennessee Department Public Health No. 931

PURPOSE: To record results of tuberculin tests of individuals.

EXPLANATION AND DEFINITIONS:

District: Civil district in which person lives.

Amount: Record here the dosage of tuberculin given. If Old Tuberculin is used, the dilution 1:10,000 equals 0.01 mg., and 0.01 mg. is recorded. This is the strength recommended for testing for diagnostic purposes.

Result: The reaction - positive or negative - to the test dose is recorded here. Tests are read according to extent of reaction as follows:

Negative - No redness or edema surrounding the injection site or an area of edema less than 5 mm. in greatest diameter.

One-plus - An area of edema surrounding the injection site of as much as 5 but less than 10 mm. in greatest diameter.

Two-plus - Edema measuring 10 or more but less than 15 mm. in greatest diameter.

Three-plus - Edema of 15 or more mm. in greatest diameter.

Four-plus - Any reaction regardless of size which results in necrosis.

OFFICE MECHANICS AND FILING: Identifying data, date and amount are recorded on the card by health officer or nurse when the test is given. After the reaction has been recorded on the card, date of test, result and amount should be entered on the Tuberculosis Record or Health Record of the individual. Example: 5/25/47 ++/.01 O.T. Tuberculin tests should not be counted for monthly tabulations unless results of tests have been recorded.

If the patch test is used, record in the same way, using P. as the dosage. Example: 5/25/47 ++/P.

Pages 932-933 missing

TUBERCULOSIS QUERY SHEET • CLINIC CASES • FORM 934
SIZE 8½" x 11"

[illegible]

PURPOSE: To record at regular intervals information concerning status of diagnosed cases of tuberculosis.

EXPLANATION AND DEFINITIONS: Each month, one of these sheets, containing the names of persons living in a given county who were diagnosed as having tuberculosis, one, two, three, etc., years ago at routine diagnostic clinics, is sent from the Division of Tuberculosis Control to each county health department for completion. Data from these sheets are summarized in order to study mortality and treatment of tuberculosis cases according to original clinical classification.

Residence: The residence of cases who have been hospitalized outside the county is considered as within the county. Check "residence in county, temporarily away" and record status, living, dead, etc. If a case has definitely moved from the county, give date that residence was changed.

Dead: Record date of death under cause of death - tuberculosis or other.

Hospitalization: For cases who have been hospitalized during year covered by this record, enter dates admitted and dates discharged.

Treatment for Tuberculosis: Specify type of treatment received during this period, whether received in hospital or elsewhere.

USED BY: Health officer and nurse.

OFFICE MECHANICS AND FILING: When one of these forms is received, it is filled out by the health officer or nurse and returned to the Division of Tuberculosis Control. Completed sheets are used and filed in the Division of Tuberculosis Control.

11-3-47

TUBERCULOSIS QUERY SHEET - HOSPITAL CASES - FORM 935
SIZE 8½" x 11"

TUBERCULOSIS QUERY SHEET - HOSPITAL CASES

COUNTY _____

NAME	ADDRESS	COLOR	SEX	AGE	RESIDENCE _____ 19____			STATUS _____ 19____			HOSPITALIZATION FOR TBC. SINCE _____ 19____			TREATMENT FOR TBC. SINCE _____ 19____	
					ADDRESS	STILL IN COUNTY	RES. IN COUNTY TEMP. AWAY	DATE REMOVED (RES. CHANGED)	LIVING	TUBER- CULOSIS	OTHER UNKNOWN	YES OR NO	DATE ADMITTED	DATE DISCHARGED	SPECIFY TYPE AS: PNEUMOTHORAX PNEUMONOLYSIS PHRENIC PARALYSIS THORACOPLASTY, ETC.

* IF A CASE HAS BEEN HOSPITALIZED, CONSIDER RESIDENCE WITHIN COUNTY AND FIND OUT STATUS--LIVING, DEAD, ETC.

THE PERSONS LISTED ABOVE HAVE BEEN HOSPITALIZED FOR TUBERCULOSIS UNDER THE STATE HOSPITALIZATION PROGRAM. THE DIVISION OF TUBERCULOSIS CONTROL IS MAKING A STUDY OF THESE CASES FOLLOWING ADMISSION TO THE HOSPITAL AND WILL APPRECIATE YOUR COOPERATION IN SUPPLYING US WITH THE INDICATED INFORMATION. PLEASE RETURN THE COMPLETED FORM TO DR. R. S. GASS, DIVISION OF TUBERCULOSIS CONTROL, BEN ALLEN ROAD, NASHVILLE 7, TENN.

TENNESSEE DEPARTMENT OF PUBLIC HEALTH - 935

PURPOSE: To record at regular intervals information concerning status of patients hospitalized for tuberculosis under the state hospitalization program.

EXPLANATION AND DEFINITIONS: Each month, one of these sheets, listing the names of patients living in a given county who were hospitalized because of tuberculosis six months or one, two, three, etc., years ago, is sent from the Division of Tuberculosis Control to each county health department for completion. Data from these sheets are summarized in order to study the progress of cases following admission to a hospital according to original clinical classification.

Residence: The residence of cases who have been hospitalized outside the county is considered as within the county. Check "residence in county, temporarily away" and record status, living, dead, etc. If a case has definitely moved from the county, give date that residence was changed.

Dead: Record date of death under cause of death - tuberculosis or other.

Hospitalization: For cases who have been hospitalized during period covered by this record, enter dates admitted and dates discharged.

Treatment for Tuberculosis: Specify type of treatment received during this period, whether received in hospital or elsewhere.

USED BY: Health officer and nurse.

OFFICE MECHANICS AND FILING: When one of these forms is received, it is filled out by the health officer or nurse and returned to the Division of Tuberculosis Control. Completed sheets are used and filed in the Division of Tuberculosis Control.

11-3-47

Pages 936-959 missing

APPLICATION FOR HOSPITALIZATION - FORM 960
SIZE 11" x 8½"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH

DIVISION OF TUBERCULOSIS CONTROL

APPLICATION FOR HOSPITALIZATION
(INSTRUCTIONS ON REVERSE SIDE)

NAME _____
Last First Middle

ADDRESS _____ COUNTY _____

COLOR _____ SEX _____ DATE OF BIRTH _____ MARITAL STATUS _____

OCCUPATION _____ EMPLOYER _____
Name Address

NAME OF HUSBAND OR WIFE _____

FULL NAME OF FATHER _____ FULL MAIDEN NAME OF MOTHER _____

LENGTH OF RESIDENCE IN STATE _____ IN COUNTY _____

FAMILY DOCTOR _____
Name Address

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

DIRECTIONS FOR REACHING ABOVE PERSON BY TELEPHONE _____

DATE _____

I WISH TO MAKE APPLICATION FOR ADMISSION TO A TUBERCULOSIS HOSPITAL FOR TREATMENT. I WILL REPORT PROMPTLY WHEN NOTIFIED THAT A BED IS AVAILABLE AND WILL ABIDE BY ALL RULES AND REGULATIONS OF THE HOSPITAL TO WHICH I AM ADMITTED.

SIGNATURE OF APPLICANT _____

IF APPLICANT IS UNDER 21 YEARS OF AGE, THIS PERMIT MUST BE SIGNED BY PARENT OR GUARDIAN.

DATE _____

I HEREBY GIVE MY PERMISSION FOR THE ABOVE APPLICANT TO BE HOSPITALIZED FOR TREATMENT IN A TUBERCULOSIS HOSPITAL AND I AGREE TO REMOVE THE PATIENT WHEN NOTIFIED BY THE HOSPITAL.

SIGNATURE _____

RELATION TO PATIENT _____

I WISH TO REQUEST HOSPITALIZATION FOR THE ABOVE NAMED PATIENT AND SUBMIT THE FOLLOWING CLINICAL DATA:

PREVIOUS TREATMENT FOR TUBERCULOSIS _____

HOSPITALIZATION (PLACE AND DATES) _____

COLLAPSE THERAPY (TYPE AND DATES) _____

OTHER ILLNESS OR ABNORMAL CONDITION PRESENT (DESCRIBE) _____

SIGNATURE OF FAMILY PHYSICIAN _____

BACK

INSTRUCTIONS

1. A completed application is required for each admission or re-admission to a hospital.
2. Print full name of applicant. Do not use initials.
Be sure to give full name of married women—for example: Brown, Martha Frances Smith.
3. Fill in all items as completely as possible. Give full names where names are requested, even though that person may not be living.
4. Application is to be signed by applicant and if applicant is under 21 years of age it is also to be signed by parent or legal guardian.
5. Application is to be signed by family physician requesting hospitalization. Upon discharge from hospital a summary of hospital treatment will be sent to the referring physician.
6. Physician is to give as complete information as possible in regard to previous treatment and hospitalization for tuberculosis and any illness or abnormal condition existing at present.
7. Send completed application to:

PURPOSE: To obtain an application for hospital care signed by the patient and the family physician. To obtain data identifying the patient, and a minimal amount of information regarding previous treatment for tuberculosis, and any other illness or abnormal physical condition that may be present.

EXPLANATION AND DEFINITIONS: All names are to be given in full, as the patient spells them. Address is to be the mailing address, and the county is to be the county of residence.

Previous treatment for tuberculosis is to be given with dates that such treatment was started, if possible, and duration of treatment.

Any current illness other than tuberculosis (such as diabetes, syphilis, epilepsy, drug addiction, etc.) is to be noted, if known. Any abnormal physical condition (such as blindness, deafness, crippling defects, or pregnancy with approximate duration is to be noted, if known.

If applicant is under age, permit must be signed by a parent or legal guardian (if married, by husband).

USED BY: Health officer or nurse.

OFFICE MECHANICS AND FILING: One of these forms is to be completed for each patient for whom hospitalization is desired under the state hospitalization program. A completed application is to be forwarded to the address given on the application form for each application for admission or re-admission to a state tuberculosis hospital, or to other hospital if state aid is requested.

3-14-49

FINANCIAL CERTIFICATION - FORM 961
 SIZE 11" x 8½"

FRONT

TENNESSEE DEPARTMENT OF PUBLIC HEALTH

DIVISION OF TUBERCULOSIS CONTROL

FINANCIAL CERTIFICATION

(INSTRUCTIONS ON REVERSE SIDE)

TO:

DATE _____

NAME OF PATIENT _____

ADDRESS _____ COUNTY _____

COLOR _____ SEX _____ DATE OF BIRTH _____ MARITAL STATUS _____

IF A DEPENDENT, PERSON LEGALLY
 RESPONSIBLE FOR SUPPORT _____

Name

Address

I HEREBY CERTIFY THAT THE FINANCIAL CIRCUMSTANCES OF THE ABOVE APPLICANT FOR HOSPITALIZATION IN A STATE HOSPITAL HAVE BEEN INVESTIGATED ACCORDING TO CHAPTER 24, PUBLIC ACTS OF 1947, AND THE FOLLOWING RECOMMENDATION IS MADE:

- ☐ 1. THE PATIENT, OR PERSON LEGALLY LIABLE FOR HIS SUPPORT, CANNOT PAY ANY PART OF THE HOSPITAL RATE.
- ☐ 2. THE PATIENT, OR PERSON LEGALLY LIABLE FOR HIS SUPPORT, CAN PAY ONLY PART OF THE HOSPITAL RATE, THE AMOUNT BEING \$ _____ PER DAY.
- ☐ 3. THE PATIENT, OR PERSON LEGALLY LIABLE FOR HIS SUPPORT, CAN PAY THE FULL HOSPITAL RATE OF \$8.00 PER DAY.
- ☐ 4. THE PATIENT HAS HOSPITALIZATION INSURANCE WHICH WILL PAY \$ _____ PER DAY FOR A PERIOD OF _____ DAYS.

NAME OF INSURANCE COMPANY _____

NAME OF EMPLOYER, IF GROUP INSURANCE _____

POLICY NUMBER _____

SEND CLAIM TO _____

Name

Address

CERTIFIED BY _____ COUNTY _____

BY _____ TITLE _____

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE AND THE RECOMMENDATIONS ARE ACCEPTABLE.

SIGNATURE OF APPLICANT OR PERSON LEGALLY RESPONSIBLE _____

BACK

CHAPTER 24—PUBLIC ACTS OF 1947

SECTION 1. "The expenditure of public funds for the control of tuberculosis, and the isolation and treatment of persons ill with tuberculosis shall be considered as expenditures for the protection of the public health, and not as funds expended for welfare or relief."

SECTION 5. "The Commissioner of the Department of Public Health, after conference with the Commissioner of the Department of Public Welfare, may make such rules and regulations as may be deemed necessary to collect any part or all of the established per diem cost from a person hospitalized, or from the person or persons legally liable for his support, who may have income or estate sufficient to make such reimbursement without materially affecting their economic support or obligations or responsibilities to dependents. All funds so collected are to be treated as expendable receipts and are to be used for the operation of said hospitals."

SECTION 6. "Any person ill with tuberculosis who is considered acceptable for treatment under the regulations promulgated by the Commissioner of the Department of Public Health governing admissions to a state tuberculosis hospital may be admitted without cost when the person to be hospitalized, or the person or persons legally responsible for his support is unable to pay, in whole or in part, the established per diem cost of hospital care. The Department of Public Welfare may be requested to make field investigations."

INSTRUCTIONS

1. This form is to be used only with applications for admissions to state owned tuberculosis hospitals.
2. Certification by the Department of Public Welfare is needed only in the few cases where the local health department is not able to determine the ability of the patient, or the person responsible for his support, to pay for hospital care. In most instances, the local health department representative will be able to certify that the patient is either able to pay all costs or none.
3. This form is to be prepared in duplicate. The original is to be forwarded with the application form to the address given on that form. The copy is to be retained by the local health department.
4. If the applicant is certified as being able to pay a part or all of the hospital costs as specified in Section 5 of Chapter 24, Public Acts of 1947, his check or money order for the amount required for 120 days of hospitalization should be forwarded with the application (Form 960) and this form. All payments should be made payable to the Tennessee Department of Public Health.

PURPOSE: To obtain information regarding the ability of the person or persons legally liable for his support, to pay the per diem cost of care in a state tuberculosis hospital.

EXPLANATION AND DEFINITIONS: Sections of the law providing for the maintenance and operation of state tuberculosis hospitals by the Department of Public Health are printed on the back of this form.

The person or persons legally liable for support are:

1. Parents or legal guardian for minor children.
2. A husband is responsible for the support of his wife.

If the patient, or person or persons legally liable for his support, is able to pay all or part of the per diem cost, his check or money order for a period of 120 days and at the rate specified, is to be forwarded to the Division of Tuberculosis Control with Forms 960 and 961. All checks and money orders are to be made payable to the Tennessee Department of Public Health.

If the patient has hospitalization insurance, complete data should be given. It should be determined that the policy is in force, and that hospitalization for tuberculosis is covered. NOTE: Many policies exclude tuberculosis.

USED BY. Health officer or nurse, and local department of public welfare.

OFFICE MECHANICS AND FILING: When a patient is recommended for hospitalization in a state hospital, the identifying data are filled in by the health officer or nurse. The local health department may in most instances certify as to the ability of the patient or person legally responsible to pay for hospital care. In cases where this cannot be determined by the local health department the case is referred to the local department of public welfare.

This form should be completed in duplicate. The original is to be sent with Application for Hospitalization, Form 960, to the address given on the application form. The duplicate copy is to be retained by the local health department.

3-14-49

Pages 962-968 missing

SUMMARY OF HOSPITAL TREATMENT - FORM 969
SIZE 5" x 8"

FRONT

SUMMARY OF HOSPITAL TREATMENT

HOSPITAL: _____ CASE NUMBER: _____

Name: _____ Color: _____ Sex: _____ Age: _____ Admission Date: _____

Address: _____ County: _____ Discharge Date: _____

Primary Diagnosis: _____

Classification: _____

Treatment (Date, Type and Side): _____

Complications (Extra-Pulmonary Tuberculosis and Complications of Treatment): _____

Status on Discharge: _____

Admission Sputum: _____ Date of Last Positive Sputum: _____ Discharge Sputum: _____

See reverse side.

BACK

Recommendations: _____

Patient to Have: Absolute Bedrest: _____ Bathroom Privileges (if in House): _____

Up for Meals: 1 _____ 2 _____ 3 _____ Hours Up _____ in A.M. _____ in P.M.

Note: Start with _____ minutes up in morning and in afternoon after rest period. Increase both morning and afternoon, by five minutes until above hours are reached.

All thoracoplasty cases are to lie on rolled pillow for eight hours each day for six months after date of last stage operation.

Follow up: Re-Xray _____ Nursing Visits _____ Sputum: _____

Discharge Address: _____

Referred to Dr. _____ Address: _____

Referred to: _____ County Health Department

SUMMARY OF HOSPITAL TREATMENT - FORM 969

PURPOSE: To provide the local health department, and the local physician in charge of the case, with information concerning treatment received in the hospital, and recommendations of the hospital physician concerning future care and treatment of patients hospitalized under the state hospitalization program.

EXPLANATION AND DEFINITIONS: The type of treatment and date it was instituted are shown on this form. The date of last stage of thoracoplasty is to be used in determining future schedule of exercise, etc., of patient. Example: Patient had ribs removed from the left side 1/12/46, 2/2/47, 2/23/47. Recommendation - 6 months of bed rest and rolled pillow under side. The patient should have 6 months of bed rest dating from the date of last operation, 2/23/47.

USED BY: Health officer, nurse and clerk.

OFFICE MECHANICS AND FILING: Two of these forms are sent to the local health department, one for the private physician in charge of the case and one for the county health department. The clerk should mail one copy immediately to the private physician concerned. The other copy should be given to the health officer for his information and then should be given to the nurse.

Data from this form should be entered on the Tuberculosis Record, Form 920, of the patient in the appropriate spaces. After the nurse has finished with this summary, the clerk attaches it to the x-ray reports of that individual.

In some sections of the state only one copy is sent to the local health department and the other copy is sent directly to the private physician.

3-14-49

GENERAL INSTRUCTIONS FOR REPORTING AND FILING

It is realized that no standard distribution of time can be arranged, but past experience has taught that much effort and lost motion may be saved by orderly procedure. The following suggestions are offered for possible assistance to clerks in local health departments:

ROUTINE HANDLING OF DAILY REPORTS

General

The daily report sheet, which is handed to the clerk, carries notation of work done, and records of all services rendered are attached to it, including new case records, new family folders, closed records, records of re-admitted patients, and records which are to be transferred.

Clerical Routines on Receipt of Day's Record.

1. Check daily report against records for accurate coding and for completeness.
2. Index all new records.
3. Close all records sent in with dailies for closing, add information to index card. The index cards remain in the general file. Closed maternity, crippled children, tuberculosis and communicable disease records, by type, are placed in the closed files for the current year.
4. Make necessary transfers. Check to see that the index card corresponds with the place of filing record.
5. Readmit cases or families as indicated.
6. Check each health record of infant, preschool and elementary school age child against inoculation card file. Record all inoculations found for that child.
7. Check each infant and closed maternity record against Summary Card-Birth File to see that the birth is reported. If birth is registered, write "Yes" and record the date in designated space on each record. Make Unreported Birth Cards, Form 102, for those infants whose births are not recorded.
8. Check each case of reportable disease, all new communicable disease field records, venereal disease records, and tuberculosis records against Office Report Card File, Form 206, for reporting.
9. Check all new Crippled Children's field records against Crippled Children's Service Roster for reporting.

Filing Daily Reports

File each worker's dailies together for the month on U-File-M-Binders. A summary sheet of month's work is prepared for each worker at the end of the month and the clerk routes this summary sheet back to the worker. After monthly tabulation is made the worker's dailies are filed. These are filed for the period of one year, by name of worker.

CLOSED FILES

The closed files consists of:

1. Family Folder File.
2. Age group records (Infant and Preschool, School and Health), in one alphabetical arrangement.
NOTE: The closed Family Folder File, Infant and Preschool, School, Health and Family Records may be combined into one alphabetical arrangement.
3. Maternity - closed current year, and closed previous years in alphabetical arrangements.
4. Tuberculosis Record - closed current year, and closed previous years in alphabetical arrangements.
5. Venereal Disease - closed current year combined with closed previous years in one alphabetical arrangement.
6. Communicable Disease Field Record, by type - closed current year, and closed previous years in alphabetical arrangements.
7. Crippled Children's Record - Closed current year, and closed previous years, in alphabetical arrangements.

Note is made inside the family folder of date admitted, name of individual, type of record, date closed and remarks for each individual record form closed. Notation is made on index card and the record is then filed in proper file. The closed records for individuals served in the current year are kept separate until necessary annual summaries and reports have been made. (See *Clerical Routines on Receipt of Day's Record, Item 3*).

LABORATORY REPORTS

Copy results of reports returned from the laboratory to case records and file alphabetically by type. Reports for the current month may be kept together until end of month.

INOCULATION CARDS

1. Copy record of tests and inoculations of children to health record of infant, preschool and elementary school age children. Mark card to show that inoculation has been recorded.
2. In filing inoculation cards, summarize inoculations of one type for one individual to one card. Keep new typhoid and smallpox cards and old diphtheria, tuberculin and whooping cough cards. *EXCEPTION:* When the typhoid immunization card for an individual is filed and the clerk finds a card in the general immunization card file for this individual showing previous typhoid inoculations, the old card should be destroyed without transferring the information to the current card.
3. Hold out incomplete cards until expiration date, then record, tabulate and file.
4. Whenever a new Health Record is made on an infant, preschool or elementary school age child, copy the record of all inoculations for which there is a record in the health department.

5. At the completion of clinics, all test and inoculation cards should be checked against health records of infants, preschool and elementary school age children for recording. When records are not in designated folders these cards should be checked against index cards.
6. Keep Summary of Tests and Inoculations, Form 229, for each batch of cards counted and filed. Keep monthly reports and combine for the year.

MORBIDITY REPORTS

1. Send out weekly morbidity report cards to each doctor on Wednesday, dated the following Saturday. Send the returned cards to the Tennessee Department of Public Health on Monday or earlier if necessary. These cards must be available in the central office on Tuesday morning to be included in the weekly report and the report to U.S. Public Health Service.
2. Make Communicable Disease Office Report Card, Form 206, for each case of a reportable disease. File alphabetically in current year file. Write "Died" and date of death on face of card for cases who have died, either after case was reported or on cases reported by death certificate. An asterisk, in red, beside the number of the case shall be used to designate cases reported by death certificates only. Write "Clinic" on line for physician for each case reported by clinic.

Rosters of tuberculosis, syphilis, typhoid carriers and malignant neoplasms are composed of all cards made for cases in previous years. These rosters are filed in two sections - (1) active, (2) closed.

3. Keep Chronological Card, Form 207, showing date, name and number of case for the year.

NOTE: The case should not be entered on Form 207, or Form 206, until case has first been reported on weekly morbidity report card.

4. Send memorandum to health officer and nurse of cases of diphtheria, bacillary dysentery, encephalitis, meningococcus meningitis, paratyphoid fever, poliomyelitis, Rocky Mountain spotted fever, smallpox, tularemia, typhoid fever, typhus fever, undulant fever, tuberculosis, and other communicable diseases necessitating epidemiological studies.
5. Keep spot maps and graphs of cases of typhoid, diphtheria, scarlet fever, smallpox, etc.

VITAL STATISTICS

Birth Certificates

1. Check to see if certificate is complete and that data are consistent.
2. Make a Summary Card-Birth, Form 101, for each certificate accepted and for each photostatic copy of certificate received. Photostatic copies are then destroyed. They must not be given out.
3. Make Unreported Birth Card, Form 102, for each infant whose birth has not been reported.

4. A monthly record may be kept of the number of births by color reported by each doctor and midwife.
5. Send the original birth, death and stillbirth certificate to the State Registrar so that they will reach that office on or before the 10th of the month.
6. Two Notification Post Cards, Form 228, for whooping cough and diphtheria, are prepared by the clerk at the time that the birth certificate of a child, resident of the area, is received. These cards are addressed and filed under dates set out in instructions for Form 228. For the clerk's convenience these cards may be arranged in a weekly mailing file.

Death Certificates

1. Check to see if certificate is complete and that data are consistent.
2. Make a Summary Card-Death, Form 121, for each death certificate accepted and for each photostatic copy of certificate received. Photostatic copies are then destroyed. They must not be given out.
3. Check Summary Cards-Death for persons having any reportable disease against Office Report Card File, Form 208.
4. When it is found that a case of reportable disease shown on death certificate has not been reported, report on Weekly Morbidity Card, enter on Chronological Card and make Communicable Disease Office Report Card. A list of such deaths, including tuberculosis, is submitted to the health officer.
5. Check all Summary Cards-Death for children under one year of age against Summary Card-Birth File, and against Diphtheria and Whooping Cough Notification Post Card File, Form 228.
6. If birth has not been reported enter identification data on Unreported Birth Card, Form 102.
7. Make Unreported Death Card, Form 122, of each death not reported.
8. Code causes of death according to the Manual of the International List of Causes of Death and Joint Causes of Death.
9. Make graph of infant death rate, and graphs showing death rates for locally important causes (diphtheria, typhoid, etc.)

Stillbirth Certificates

1. Check to see if certificate is complete and that data are consistent.
2. Make a Summary Card-Stillbirth, Form 141, for each certificate accepted and for each photostatic copy of certificate received. Photostatic copies are then destroyed. They must not be given out.
3. Check each stillbirth against Unreported Birth Card File.

Vital Statistics Tables for County Health Departments

1. Fill in Table 1, using resident data, showing live birth, death and stillbirth rates, and neonatal, infant and puerperal death rates.
2. Make annual compilation of resident live births and stillbirths according to attendant, color and place of birth and stillbirth.
3. Make annual compilation of resident deaths by cause, age and color, with details on infant mortality and maternal deaths. The classification should be based on the Manual of the International List of Causes of Death and Joint Causes of Death.
4. Table IV, using recorded data, may be kept monthly by local health departments if necessary. NOTE: Recorded data for each county are given in The Spotlight, a monthly publication of the Division of Vital Statistics.
5. Tables I, II, III, V and VI should be completed after the March certificates have been received, using the preceeding year's resident data obtained from the Summary Cards-Birth, Death and Stillbirth Files.
6. See instructions in Vital Statistics Bulletin regarding resident data.
7. When completed, these tables should be routed to the health officer, nursing staff and sanitarian.

MONTHLY CALENDAR

1. Send in Monthly Report of Official Mail to Washington on last calendar day of each month.
2. Venereal Disease Control Activity Report is due in Nashville on the fifth of the following month. Send two copies, keep one in files.
3. Travel and Contingent Expense Accounts are due in the central office on the fifth of the following month. Send two copies, keep one in files.
4. Original vital statistics records are due in Nashville on or before the tenth of the following month.
5. Pay-roll for current month and Attendance Record for previous month are due in Nashville on the fifteenth of the month. Send one copy, keep one in files. Send a copy of the Attendance Record to the regional office.
6. Monthly report of activities, Form 19, is prepared by the fifteenth of each month and kept in the local department. A quarterly report is prepared and sent to the regional office before the fifteenth of the month following close of quarter. Send one copy to regional office and keep one copy in files.

Pages App. 6-App. 9 missing

REFERENCE MATERIAL FURNISHED BY THE TENNESSEE DEPARTMENT OF PUBLIC HEALTH

ACUTE COMMUNICABLE DISEASES:

Diphtheria. Tennessee Department of Public Health.

Guide for Teachers - Communicable Diseases Among School Children. (Placard).
Tennessee Department of Public Health.

Recommended Immunization Procedures. (Placard). Tennessee Department of Public
Health.

Regulations Governing Communicable Diseases in Tennessee. Tennessee Department
of Public Health.

Smallpox. Tennessee Department of Public Health.

Typhoid. Tennessee Department of Public Health.

Whooping Cough. Tennessee Department of Public Health.

INDUSTRIAL HYGIENE:

Cartoon Poster for Industrial Washrooms. Tennessee Department of Public Health.

Health Services for Industry. Tennessee Department of Public Health.

Industrial Health Standards. Tennessee Department of Public Health.

Outline of an Industrial Hygiene Program. Tennessee Department of Public Health.

Packing Lunches for the Industrial Worker. Tennessee Department of Public Health.

Reprint of the Industrial Hygiene Act, Chapter 129, House Bill 655, Public Acts,
General Assembly, 1945.

Respirators Approved for Protection Against the Inhalation of Mineral Dusts.
Tennessee Department of Public Health.

Tennessee Industrial Hygiene News. Tennessee Department of Public Health.

Only one each of the following will be sent to local health departments:

Absenteeism in Tennessee Industrial Plants Caused by Diseases of the Teeth and
Gums. (Reprint).

Agriculture. The Bureau of Educational Services, 401 Broadway, New York 13, N. Y.

Ammonia. U.S. Department of Labor, Division of Labor Standards, Washington, D.C.

INDUSTRIAL HYGIENE (CONT'D):

At Your Service. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Below the Belt. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Better Check Up. National Dental Hygiene Association, Washington, D.C.

Catalog of Free Health and Grooming Material. Educational Service Department, Bristol - Myers Company, New York 20, N.Y.

Clara Gives Benzol the Run Around. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Cleanliness and Health. Cleanliness Bureau, 11 West 42nd Street, New York 18, N.Y.

Contribution of Petroleum. The Bureau of Educational Services, 401 Broadway, New York 13, N.Y.

Don't Be An Ostrich - Face These Facts. Office of The Secretary of War, Civilian Medical Division, Washington, D.C.

Formaldehyde. U.S. Department of Labor, Division of Labor Standards, Washington, D.C.

Help for You. Mississippi State Board of Health, Jackson, Mississippi.

Industrial Job Placement of Persons with Inactive Tuberculosis - A Guide for Employment Managers and Personnel Directors. National Tuberculosis Association, 1790 Broadway, New York 19, N.Y.

Industrial and Occupational Environment and Health. (Reprint).

K O by C O gas. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Let's See. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Occupation Hazards and Diagnostic Signs. U.S. Department of Labor, Division of Labor Standards, Washington, D.C.

Qualifications of an Industrial Nurse. National Association of Manufacturers, Industrial Relations Department, New York 20, N.Y.

Reconversion for Health. Office of The Secretary of War, Civilian Medical Division, Washington, D.C.

Standing Orders for Nurses in Industry. Council on Industrial Health, American Medical Association, Chicago 10, Illinois.

That Tired Feeling. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

The Industrial Nurse and Her Job. Safety Engineering Department, Wausau, Wisconsin.

The Nurse in the Industrial Field. National Organization for Public Health Nursing, New York 19, N.Y.

INDUSTRIAL HYGIENE (CONT'D):

The Nurse in the Industrial Health Program. National Organization for Public Health Nursing, New York 19, N.Y.

Trouble in the Midriff. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

Use and Value of Industrial Vital Statistics. (Reprint)

Willie's Victory Torch. Federal Security Agency, U.S.P.H.S. Washington 25, D.C.

MATERNAL AND CHILD HYGIENE:

Collapsible Baby Bed. Tennessee Department of Public Health.

Dental Kit - Elementary School. Tennessee Department of Public Health and Tennessee Department of Education.

Dental Kit - High School. Tennessee Department of Public Health and Tennessee Department of Education.

General Nursing Follow-up Instructions for Crippled Children. Tennessee Department of Public Health.

Homemade Heated Premature Bed. Tennessee Department of Public Health.

Infant Care. U.S. Department of Labor, Children's Bureau, Washington 25, D.C.

Keeping the Baby Well. Tennessee Department of Public Health.

Plan Your Meals for Health and Happiness. Tennessee Department of Public Health.

Prenatal Care. U.S. Department of Labor, Children's Bureau, Washington 25, D.C.

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INDEX

Absence, Request for Leave	15
Acknowledgment, Typhoid Carrier	215
Activity Report, Venereal Disease Control	238
Additions - Register, Corrections, Removals	172
ADMINISTRATION	1-99
Admission and Discharge Card, Hospital (C.C.S.)	448
Agglutination Test Report	611
Analysis of Milk Sample, Report of	328
APPENDIX	App. 1-99
Application:	
Disinterment Permit	127
Hospitalization (Tuberculosis).	960
Milk Permit	331
Permit for Impoundage and Maintenance of Impounded Water	281
Permit for Impoundage Construction	280
Appointment for Examination	502
Attendance:	
Record, Monthly	5
Summary Card, Yearly	16
Authorization for Services (C.C.S.)	445
Bacteriological:	
Milk Examination Report	605
Water Examination	603
Balance Sheet, Monthly	24
Births:	
Certificate, Delayed	110
Certificate of	100
Delayed Registration of Births - Instructions	111
Greetings to Parents	115
Institution Report	104
Report of Failure to File Birth Certificate	105
Report of Foundling	109
Request for Birth Registration - Identification Card	107
Request for Certified Copy, Certificate of	106
Summary Card	101
Unreported Birth	102
Box Check	505
Burial Transit Permit	128
Carrier:	
Typhoid, Acknowledgment	215
Typhoid, Record	214
Casket Dealers and Institution Reports, Check Sheet	132
Casket Notice	131
Certain Tests and Inoculations, Summary of	229

The sections are shown by capital letters.

Certificate:

Birth, Delayed	110
Death	120
Health, of Milk Handler	329
Live Birth	100
Medical, Marriage License	237
Stillbirth	140

Certification, Financial (Tuberculosis)	961
---	-----

Certified Copy:

Certificate of Birth	106
Certificate of Death	126
Certificate of Divorce	166
Certificate of Marriage	156

Check Sheet:

Box Check	505
Casket Dealers and Institution Reports	132
Monthly Balance Sheet	24
Child Health Service - Cooperative Program	416
Chronological Card	207
Claim for Travelling Expenses	11
Classroom Work Sheet - Cooperative Program	415
Clerical, General Instructions for Reporting and Filing	App. 1-5
Clinic Cases, Tuberculosis Query Sheet	934
Clinic Organization Sheet, Tuberculosis.	910
Code for Daily Report	2
Commitment (C.C.S.)	442

Communicable Disease:

Agglutination Test Report	611
Application for Permit for Impoundage and Maintenance of Impounded Water	281
Application for Permit for Impoundage Construction	280
Chronological Card	207
Formal Notice of Isolation or Quarantine	216
Immunization Cards	220-223
Isolation or Quarantine Release	217
Miscellaneous Examination Request Form	600
Miscellaneous Report Form	606
Notification Post Card	228
Office Report Card	206
Record	210
Reference Material	App. 10-16
Summary of Certain Tests and Inoculations	229
Typhoid Carrier Acknowledgment	215
Typhoid Carrier Record	214
Weekly Morbidity Card	200
Complaint of Nuisance	302
Confidential Efficiency Report	18
Contingent - Expense Account	10

Continuation Sheet:

Crippled Children Field Record	436-A
Health Record	408-A
Maternity	400-A
Tuberculosis	920-a

Cooperative Program:

Child Health Service	416
Classroom Work Sheet	415
Report of Examinations and Corrections - Dental	480
Summary Report - Dental	484

Crippled Children:

Authorization for Services	445
Commitment	442
Educational Needs for a Handicapped Child	460
Examination Record	440
Field Record	436
Field Record - Continuation Sheet	436-A
Hospital Admission and Discharge Card	448
Physician's Follow-Up Instructions	452
Reference Material	App. 12-13
Referral to Vocational Rehabilitation	456
Summary Record	437

Daily:

Mileage Sheet	12
Report	1
Report, Code for	2

Dairy Products Tag	604
------------------------------	-----

Data Sheet, Supplemental Social and Economic	501
--	-----

Death:

Application for Disinterment Permit	127
Burial Transit Permit	128
Casket Notice	131
Certificate of	120
Check Sheet for Casket Dealers and Institution Reports	132
Delayed Report of Diagnosis	129
Institution Report - Deaths and Stillbirths	124
Monthly Report of Funeral Directors and Retail Casket Dealers	130
Report of Failure to File Death Certificate	125
Request for Certified Copy of Certificate	126
Summary Card	121
Unreported Death	122

Degrading:

Notice of	327
Warning of	326

Delayed:

Certificate of Birth	110
Registration of Births - Instructions	111
Report of Diagnosis	129

Dental:

Report Card	476
Report of Examinations and Corrections	480
Summary Report	484

Diagnosis, Delayed, Report of	129
---	-----

Diphtheria Immunization Card	221
--	-----

<i>DISEASES, PREVENTABLE</i>	200-299
--	---------

Disinterment Permit, Application for	127
--	-----

Divorce, Request for Certified Copy of Certificate	166
--	-----

Eating and Drinking Establishment Inspection Record	338
Eating and Drinking Establishments Inspection Form	339
Educational Needs for a Handicapped Child	460
Efficiency Report, Confidential	18
Epidemiological Report (Venereal Disease)	233
Examination:	
Appointment for	502
of Milk Handler, Record of	330
Record (C. C. S.)	440
Examinations and Corrections, Report of (Dental)	480
Examination and Treatment Release (Venereal Disease)	243
Examination Request Form:	
Miscellaneous	600
Water	602
Expense Account Form:	
Contingent	10
Travel	11
Failure to File:	
Birth Certificate	105
Death Certificate	125
Family:	
Folder	500
Record	413
Field Record:	
Communicable Disease	210
Crippled Children	436
Epidemiological Report - White (Venereal Disease)	233
Family Record	413
Health Record	408
Maternity	400
Sanitary Survey of Home	300
Sanitary Survey of School	311-312
Tuberculosis Record	920
Typhoid Carrier Record	214
Financial Certification (Tuberculosis)	961
X-Ray examination Record	912
Folder, Family	500
Follow-Up Instructions, Physician's (C. C. S.)	452
Formal Notice of Isolation or Quarantine	216
Formal Notice of Quarantine (Venereal Disease)	242
Foundling, Birth Report of	109
Funeral Directors and Retail Casket Dealers Monthly Report	130
General Instructions for Reporting and Filing App.	1-5
Gonococci, Report of Examination for	608
Greetings to Parents	115
Handicapped Child, Educational Needs for	460
Health Certificate of Milk Handler	329
Health Record	408
Health Record - Continuation Sheet	408-A
Home, Sanitary Survey of	300
Hospital Admission and Discharge Card (C. C. S.)	448
Hospital Cases, Tuberculosis Query Sheet	935

Hospital Treatment, Summary of (Tuberculosis)	969
Hospitalization, Application for (Tuberculosis)	960
Identification Card - Request for Birth Registration	107
Immunization Card:	
Diphtheria	221
Smallpox	222
Typhoid	220
Whooping Cough	223
Impoundage and Maintenance of Impounded Water, Application for Permit	281
Impoundage Construction, Application for Permit	280
Index:	
Card	3
Reexamination, Tuberculosis	928
Industrial Hygiene, Reference Material App.	10-12
Infant, Preschool, School and Adult, Record for	408
Inoculations, Summary of Certain Tests and	229
Inspection Form for Eating and Drinking Establishments	339
Installation or Repair of Septic Tank System	301
Institution Report:	
Births	104
Deaths and Stillbirths	124
Instructions:	
Delayed Registration of Births	111
Follow-Up, Physician's (C.C.S.)	452
General, for Reporting and Filing App.	1-5
Isolation and Quarantine by Court, Order of (Venereal Disease). . .	241
Isolation and Quarantine by Health Officer, Order of (V. D.) . . .	240
Isolation or Quarantine, Formal Notice	218
Isolation or Quarantine Release	217
LABORATORY	600-699
Laboratory Forms:	
Agglutination Test Report	611
Bacteriological Milk Examination Report	605
Bacteriological Water Examination	603
Dairy Products Tag	604
Miscellaneous Examination Request Form	600
Miscellaneous Report Form	606
Pre-Marital Seriological Test	610
Report of Examination for Gonococci	608
Report of Examination for Tubercle Bacilli	609
Serologic Test for Syphilis (Duplicate)	610-2
Serologic Test for Syphilis (Triplicate)	610-3
Water Examination Request Form	602
Leave of Absence, Request for	15
License, Marriage, Medical Certificate for	237
Live Birth, Certificate	100
Marriage:	
License, Medical Certificate for	237
Request for Certified Copy, Certificate of	156
Mass X-ray Survey Examination Record	905
Material, Reverence App.	10-16
MATERNAL AND CHILD HYGIENE	400-499
Maternal and Child Hygiene, Reference Material App.	12-13

Maternity:

Record	400
Record - Continuation Sheet	400-A
Report of Nursing Visit to Maternity Case	402

Medical:

Center Records (Venereal Disease)	240-244
Certificate for Marriage License	237
Medical Centers, Voluntary Patient Consent for Admission to	244
Midwife Record	405
Mileage Sheet, Daily	12

Milk:

Application for Milk Permit	331
Bacteriological Examination Report	605
Dairy Products Tag	604
Health Certificate of Milk Handler	329
Milk Permit	332
Milk Plant - Producer Inspection Form	325
Milk Producer - Distributor Inspection Form	324
Notice of Degrading	327
Pasteurization Plant Inspection Form	323
Pasteurization Plant Inspection Record	320
Plant-Producer Inspection Record	321
Producer-Distributor Inspection Record	322
Record of Examination of Milk Handler	330
Report of Analysis of Milk Sample	328
Warning of Degrading	326

MISCELLANEOUS	500-599
-------------------------	---------

Miscellaneous:

Examination Request Form	600
Reference Material	App. 13
Report Form	606

Monthly:

Attendance Record	5
Balance Sheet	24
Report of Funeral Directors and Retail Casket Dealers	130
Report to Vital Statistics	190
Tabulation	19
Morbidity Report Card, Weekly	200

Needs for a Handicapped Child, Educational	460
--	-----

Notice:

Casket	131
Degrading	327
Isolation or Quarantine	216
Notification post Card	228
Nuisance, Complaint of	302
Nursing Visit to Maternity Case, Report of	402

Office Report Card, Communicable Disease	206
--	-----

Order of:

Isolation and Quarantine by Court (Venereal Disease)	241
Isolation and Quarantine by Health Officer (Venereal Disease).	240
Organization Sheet, Tuberculosis Clinic	910

Parents, Greetings to	115
Pasteurization Plant Inspection Form	323
Pasteurization Plant Inspection Record	320
Patient Consent for Admission to Medical Centers, Voluntary	244
Payroll	4
Permit:	
Application for Disinterment	127
Application for Milk	331
Burial Transit	128
Impoundage and Maintenance of Impounded Water, Application for	281
Impoundage Construction, Application for	280
Milk	322
Physician's:	
Follow-Up Instructions (C.C.S.)	452
Venereal Disease Report Card	204
Weekly Morbidity Card	200
Plant-Producer Inspection Record	321
Post Card, Notification	228
Premarital Serological Test	610
<i>PREVENTABLE DISEASES</i>	200-299
Producer-Distributor Inspection Record	322
Quarantine:	
by Court, Order of Isolation (Venereal Disease)	241
by Health Officer, Order of Isolation (Venereal Disease) . . .	240
Formal Notice of (Venereal Disease)	242
Formal Notice of Isolation or	216
or Isolation Release	217
Query Sheet:	
Tuberculosis - Clinic Cases	934
Tuberculosis - Hospital Cases	935
Record of Examination of Milk Handler	330
Record of Tumor Clinic Patient	560
Reexamination Index, Tuberculosis	928
Reexamination, X-ray Record	913
Reference Material	App. 10-16
Referral from C.C.S. to Vocational Rehabilitation	456
Referral Record, Tumor Clinic	550
Register Additions, Corrections and Removals	172
Release, Isolation or Quarantine	217
Report:	
Agglutination Test	611
Analysis of Milk Sample	328
Bacteriological Milk Examination	605
Birth of Foundling	109
Code for Daily	2
Confidential Efficiency	18
Daily	1
Dental Card	476
Epidemiological Report (Venereal Disease)	233
Examinations and Corrections (Dental)	480
Examination for Gonococci	608
Examination for Tubercle Bacilli	609
Failure to File Birth Certificate	105

Report: (Cont'd)

Failure to File Death Certificate	125
Institutional - Births	104
Institutional - Deaths and Stillbirths	124
Of Diagnosis - Delayed (Vital Statistics)	129
Miscellaneous Form (Laboratory)	606
Monthly, Funeral Directors and Retail Casket Dealers	130
Monthly, Vital Statistics	190
Nursing Visit to Maternity Case	402
Summary - Dental	484
Venereal Disease Control Activity	238
X-ray, Small Film	906

Report Card:

Dental	476
Communicable Disease Office	206
Venereal Disease	204
Weekly Morbidity	200

Reporting and Filing, General Instructions App. 1-5**Request:**

Birth Registration - Identification Card	107
Certified Copy, Certificate of Birth	106
Certified Copy, Certificate of Death	126
Certified Copy, Certificate of Divorce	166
Certified Copy, Certificate of Marriage	156
Form for Miscellaneous Examination	600
Form for Water Examination	602
Leave of Absence	15

Requisition for Supplies 9**Roster, School 420****SANITATION 300-399****Sanitation Forms:**

Application for Milk Permit	331
Bacteriological Milk Examination Report	605
Bacteriological Water Examination	603
Complaint of Nuisance	302
Dairy Products Tag	604
Eating and Drinking Establishment Inspection Record	338
Health Certificate of Milk Handler	329
Inspection Form for Eating and Drinking Establishments	339
Installation or Repair Record of Septic Tank System	301
Milk Permit	332
Milk Plant-Producer Inspection Form	325
Milk Producer-Distributor inspection Form	324
Notice of Degrading	327
Pasteurization Plant Inspection Form	323
Pasteurization Plant Inspection Record	320
Plant-Producer Inspection Record	321
Producer-Distributor Inspection Record	322
Record of Examination of Milk Handler	330
Reference Material	App. 14
Report of Analysis of Milk Sample	328
Sanitary Survey of Home	300
Sanitary Survey of School	311-312
Score Sheet for School Cafeteria	313
Water Examination Request Form	602
Warning of Degrading	326

School:

Child Health Service - Cooperative Program	416
Classroom Work Sheet - Cooperative Program	415
Roster	420
Sanitary Survey of	311-312
Score Sheet for Cafeteria	313

Serologic Test:

Pre-Marital	610
Syphilis (Duplicate)	610-2
Syphilis (Triplicate)	610-3
Services, Authorization for (C.C.S.)	445
Small Film, X-ray Report	906
Smallpox Immunization Card	222
Social and Economic Data, Supplemental	501
Special Education, Reference Material	App. 14-15

Stillbirth:

Certificate	140
Institution Report	124
Summary Card	141

Summary:

Certain Tests and Inoculations	229
Hospital Treatment (Tuberculosis)	969
Record (C.C.S)	437
Report, Cooperative Dental Hygiene Program	484

Summary Card:

Birth	101
Death	121
Stillbirth	141
Yearly Attendance	16

Supplement, Tuberculosis Record	920-b
---	-------

Supplemental Social and Economic Data	501
---	-----

Supplies, Requisition for	9
-------------------------------------	---

Survey:

Home, Sanitary	300
School, Sanitary	311-312

Syphilis:

Pre-Marital Serologic Test	610
Serologic Test for (Duplicate)	610-2
Serologic Test for (Triplicate)	610-3
Venereal Disease Record	233

Tables, Vital Statistics, for County Health Department	199
--	-----

Tabulation, Monthly	19
-------------------------------	----

Tag, Dairy Products	604
-------------------------------	-----

Test Card, Tuberculin	931
---------------------------------	-----

Tests and Inoculations, Summary of	229
--	-----

Transfer, Venereal Disease	239
--------------------------------------	-----

Transit Permit, Burial	129
----------------------------------	-----

Traveling Expenses, Claim for	11
---	----

Treatment Release, Examination and (Venereal Disease)	243
---	-----

TUBERCULOSIS	900-999
------------------------	---------

Tuberculosis Forms:

Application for Hospitalization	960
Clinic Organization Sheet	910
Financial Certification	961
Mass X-Ray Survey Examination Record	905
Query Sheet - Clinic Cases	934
Query Sheet - Hospital Cases	935

Tuberculosis Forms: (Cont'd)

Record	920
Record - Continuation Sheet	920-a
Record - Supplemental	920-b
Reexamination Index	928
Reference Material	App. 15
Report of Examination for Tubercle Bacilli	609
Summary of Hospital Treatment	969
Tuberculin Test Card	931
Work Sheet	929
X-ray Examination Record	912
X-ray Report - Small Film	906

Tumor Clinic:

Record of Patient	560
Referral Record	550

Typhoid Carrier:

Acknowledgment	215
Record	214

Typhoid Immunization Card	220
-------------------------------------	-----

Unreported:

Birth	102
Death	122

Venereal Disease:

Control Activity Report	238
Examination and Treatment Release	243
Formal Notice of Quarantine	242
Medical Certificate for Marriage License	237
Order of Isolation and Quarantine by Court	241
Order of Isolation and Quarantine by Health Officer	240
Pre-Marital Serologic Test	610
Record	233
Record - with Epidemiological Report	233
Reference Material	App. 15-16
Report Card	204
Report of Examination for Gonococci	608
Serologic Test for Syphilis (Duplicate)	610-2
Serologic Test for Syphilis (Triplicate)	610-3
Transfer	239
Voluntary Patient Consent for Admission to Medical Centers	244

VITAL STATISTICS	100-199
----------------------------	---------

Vital Statistics Forms:

Application for Disinterment Permit	127
Birth Report of Foundling	109
Burial Transit Permit	128
Casket Notice	131
Certificate of Death	120
Certificate of Live Birth	100
Certificate of Stillbirth	140
Check Sheet for Casket Dealers and Institution Reports	132
Delayed Certificate of Birth	110
Delayed Registration of Birth - Instructions	111
Delayed Report of Diagnosis	129
Greetings to Parents	115

Vital Statistics Forms: (Cont'd)

Institution Report - Births	104
Institution Report - Deaths and Stillbirths	124
Monthly Report of Funeral Directors and Retail Casket Dealers	130
Monthly Report to Vital Statistics	190
Reference Material	App. 18
Register Additions, Corrections, Removals	172
Report of Failure to File Birth Certificate	105
Report of Failure to File Death Certificate	125
Request for Birth Registration - Identification Card	107
Request for Certified Copy of a Death Certificate	128
Request for Certified Copy of Certificate of Birth	108
Request for Certified Copy of Certificate of Divorce	166
Request for Certified Copy of certificate of Marriage	156
Summary Card - Death	121
Summary Card - Live Birth	101
Summary Card - Stillbirth	141
Tables for County Health Department	199
Unreported Birth	102
Unreported Death	122
Vocational Rehabilitation, Referral from C.C.S. to	456
Voluntary Patient Consent for Admission to Medical Centers	244
 Warning of Degrading	 328
Water:	
Bacteriological Examination	603
Examination Request Form	602
Weekly Morbidity Report Card	200
Work Sheet:	
Classroom - Cooperative Program	415
Tuberculosis	929
Whooping Cough Immunization Card	223
 X-Ray:	
Mass, Survey Examination Record	905
Record - Examination	912
Report - Small Film	906
 Yearly Attendance Summary Card	 16

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